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**An investigation into
the experiences of fathers with psychosis**

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Abstract

This study involves a qualitative investigation into the experiences of 10 White/Caucasian fathers who have a diagnosis of psychosis (schizophrenia, schizoaffective or other psychotic-type disorder). Fathers with psychosis have often been ignored by the research community. This project was designed to explore some of the potential issues concerning this group, such as: What is it like to be a father with psychosis? How do they evaluate themselves in terms of fulfilling their idea of the parenting role? Do they have fears of passing on the illness to their children? Do they have fears of losing custody of their children? The collected data was analysed by means of Interpretative Phenomenological Analysis and evaluated with regard to previous research. This study found that psychosis may directly and indirectly undermine the father-child relationship and the work of parenting. The fear of one's children inheriting psychotic illness is a widespread concern amongst this group. In the process of fulfilling the role of fatherhood, men with psychosis benefit from a sense of pride in the father role, a sense of purpose to one's life, a feeling of pleasure in the creation and development of life, and motivation to change for the better. The results are used to identify possible innovations and improvements in the services received by fathers with psychosis and their families. The results were also used to suggest further avenues of research with this group.

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Chapter One:

Introduction

This section introduces psychosis. It goes on to review the normative experience of fatherhood and the literature concerning parents with serious mental illness. It ends with the articles expressing an urgent need for qualitative study of the experience of fathers with mental illness and how the present study aimed to address this need.

Psychosis

Psychosis has been defined as “...*a state of severe mental and emotional disturbance in which the affected person experiences a number of the following: fixed false beliefs (delusions); unshared perceptual experiences (hallucinations); markedly illogical and disorganised thinking (thought disorder)*” (Watkins, 1996, p1). A person experiencing psychosis is determined to be out of touch with reality.

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: APA, 1994) accepts that there are no universally accepted definitions of the term *psychotic*. In defining the various psychotic disorders, DSM-IV emphasises different aspects of the various definitions of *psychotic*. With regard to schizophrenia, schizophreniform disorder, schizoaffective disorder and brief psychotic disorder, DSM-IV defines psychotic as the presence of delusions, any prominent hallucinations, disorganised speech or disorganised or catatonic behaviour. The other

psychotic disorders, such as delusional disorder, are based on a definitions of psychotic which involve the presence of delusions, or hallucinations which are unaccompanied by insight.

Theories of psychosis

Frith (1992) suggests that hallucinations are due to a disturbance of self-monitoring in the brain. Frith proposed that people experiencing auditory hallucinations have an impaired ability to discriminate the source of inner speech, so that inner speech is not identified as originating from oneself, thereby leading to the experience of auditory hallucinations. Self-monitoring problems can also lead to delusions of control, when one misattributes behaviour to external sources. Frith reported that paranoid delusions and delusions of reference may be linked to the inability to infer the knowledge and intentions of others. The negative symptoms of schizophrenia may be linked to a deficit in the ability to supervise one's actions, making it difficult to generate behaviour in the absence of external cues. This problem with supervising action can also lead to inappropriate responses such as disordered speech and behaviour, repetition of behaviour, and responses to irrelevant stimuli.

Underlying Frith's theory is a body of neuropsychological evidence suggesting that brain abnormalities which develop before birth are implicated in the development of schizophrenia. For example, Frith reports research suggesting up to 25% of people with schizophrenia have abnormally large ventricles in their brain. There is also evidence suggesting individuals with schizophrenia have smaller temporal lobe structures in comparison to the rest of the population. Frith argues that positive symptoms of

schizophrenia arise from disconnections between brain structures responsible for willed action and structures involved with perception. These disconnections mean that corollary discharges are disrupted. Corollary discharges signal that an event is due to one's own actions rather than to an external phenomenon. Frith argues that the negative symptoms of schizophrenia are the result of damage to the brain structures responsible for action.

Garety, Kuipers, Fowler, Freeman, and Bebbington (2001) introduced a new, tentative cognitive model of the positive symptoms of psychosis. The model proposes that early adverse life experience such as severe childhood trauma may create an enduring cognitive vulnerability to developing psychosis. This vulnerability takes the form of a basic cognitive disturbance, in which material from one's memory intrudes into consciousness unintentionally and there is a disturbance in how a person integrates stored material with the current sensory input. This leads to new sensory input being experienced as anomalous, ambiguous and unstructured, which in turn lead to emotional changes, such as an increase in anxiety. If a person with a predisposed cognitive vulnerability to psychosis experiences a major life event such as losing a job, this event acts as a trigger to further emotional changes and to a heightened state of arousal. The emotional changes feed back into the moment-by-moment processing of the anomalous experiences, influencing the content of those experiences. For example, a job loss might lead to feelings of anxiety and depression. There may also be anxiety arising from the experience of auditory hallucinations. These emotions will feed back into the moment-by-moment processing of the auditory hallucinations so that the hallucinations may develop a critical and threatening content: "You're useless, you won't get another job now. We're after you, we've got you marked." Biases in cognitive processing such as

externalising attributional biases may contribute to a judgement that the anomalous experiences are externally caused.

Garety et al. (2001) suggest a second possible conceptualisation of the basic cognitive disturbance associated with a vulnerability to developing psychosis. In this model, the cognitive disturbance may have developed more recently than childhood, and involves a disruption of self-monitoring of intentions and actions, so that one experiences one's own intentions to act as alien, rather than as originating from inside oneself. This second model is based on the theory of Frith (1992).

Arguments against the concept of schizophrenia

Schizophrenia is the most common diagnosis a person with psychosis will be given.

There is an increasing body of evidence which suggests that the symptoms of psychosis might be a common end-state in a range of disorders, which includes schizophrenia. It has been suggested that the diagnosis of schizophrenia could be broadened into psychotic and non-psychotic categories to reflect the biological and clinical changes which occur before someone becomes psychotic (Tsuang, Stone and Faraone, 2000).

Bentall, Jackson and Pilgrim (1988) argued against the validity of the schizophrenia diagnosis itself and suggested that alternative models of classifying abnormal behaviour might be used, although these authors admit that there is insufficient evidence to support any particular system of classification.

Boyle (2002) argued that schizophrenia is a social construction in which the assumptions which surround it are taken for granted and there is no justification for it being either a

scientific concept or a medical syndrome. It was suggested that the early research by Kraepelin, Bleuler and Schneider, (upon which the present concept of schizophrenia is based) did not present sufficient evidence to justify schizophrenia as a scientific concept because scientific concepts should be based on the observation of a pattern of regularities, and this is not the case with schizophrenia. For example, Boyle reported that Kraepelin frequently changed his mind about what were the regularities which allow *dementia praecox* to be inferred. Dementia praecox was Kraepelin's term for what was later called schizophrenia. Kraepelin's later writings in effect admitted that the manner in which he had earlier inferred dementia praecox was not meaningful. This was because he had reported that the group of people, from whose behaviour he had originally inferred dementia praecox, did not exhibit the same kind of regularities in the onset, course and outcome of their illnesses. This was in contrast to his earlier claim that this group of people did show the same kind of regularities. Boyle argued that since his inference of dementia praecox was now meaningless, Kraepelin should have started a new search for a pattern of regularities. However she reports that he did not do this. In addition, Boyle states that Kraepelin did not clearly report his methodology, so that it is extremely difficult to deduce what he actually did (Boyle, 2002).

In addition, these early researchers did not provide sufficient evidence to identify what is now called schizophrenia as a medical syndrome, a syndrome being a particular cluster of phenomena, or *symptoms*, which are reliably associated with independently and reliably measurable events or *signs*. Because symptoms have many possible antecedents, one cannot define a syndrome simply on the evidence that a cluster of phenomena hangs together because the reliability of correctly identifying the syndrome would be low.

Therefore, the identification of a syndrome is a two-stage process, in which this cluster has to be shown to be reliably associated with another feature or *sign*, which can be independently measured. A *sign* should be directly observable with a much higher degree of reliability than a *symptom*, and it is believed to have fewer antecedents than a *symptom*. It is then necessary to theoretically link the *signs* and the *symptoms* so that it can be justified that the *signs* are antecedents of the *symptoms*. Boyle argues that this process has not been done with schizophrenia and it is therefore not valid to define schizophrenia as a syndrome. For example, Kraepelin did not adequately describe signs of dementia praecox which could be theoretically linked with symptoms of dementia praecox, and he appeared to use different criteria for diagnosing dementia praecox in different people (Boyle, 2002).

The present study acknowledges the problems with schizophrenia as a scientific concept and as a medical syndrome. However, it was beyond the scope of this study to suggest a new framework for understanding schizophrenia and the other psychotic disorders. The present research sought to gain a degree of insight into the experiences of certain individuals who each have psychotic symptoms, symptoms which had been used as evidence by psychiatric services to provide them with a diagnosis of schizophrenia, schizoaffective or other psychotic-type disorder.

The prevalence of psychosis

The one year prevalence of functional psychoses was estimated as being 4 per 1000 for both women and men in the Household Survey from the UK National Survey of Psychiatric Morbidity, which was carried out in 1993 and 1994 (Meltzer, Gill, Petticrew,

and Hinds, 1995). However this rate is probably an underestimate due to the possibility that the screening procedures for psychosis lead to a number of screen negative individuals (Jenkins, Lewis, Bebbington, Brugha, Farrell, Gill and Meltzer, 1997).

The experience of psychosis

Chadwick, a psychologist, has written extensively on his personal experience of schizophrenia (Chadwick, 1997, 2001, 2002) and he argues that schizophrenia is on a continuum with *normal* functioning. He described a feeling of “existential fragility” in which he questioned whether he existed. He also talked of how schizophrenia can lead to one feeling overloaded with stimulation, in which sounds and other stimuli appear exaggerated, which can be pleasant but are often overwhelming. For example, the noise from a dog barking can be very disturbing because it is experienced as very loud. One way in which people with schizophrenia deal with this overload is to isolate themselves within their own egocentric world and keeping their attention narrowly focused. Unfortunately, people with schizophrenia often view the external world as confusing and dangerous, partly because they cannot focus outside their own intense and preoccupying experiences.

Internally, a person with schizophrenia may experience a blurring of boundaries between the unconscious and the conscious mind. The distinction between self and other is less clear than in a person who does not have psychosis. This can make a person feel “eaten into” or “taken over” by others, which can be disturbing. Consequently, people with schizophrenia may prefer more superficial relationships with others. People with schizophrenia have difficulty organising their experiences into discrete categories, which

can lead a need to do either everything or nothing at all. They often experience delusions, particularly ones in which they believe that they are under threat. However, delusions can provide a “comfort of certainty” in the midst of a confusing world, in which the logic of a delusion is used to explain phenomena. Schizophrenia can also make one feel fragmented and cause one to make loose associations, in which one makes connections between extremely disparate phenomena. Schizophrenia also involves experience of an external locus of control, in which one’s thoughts and actions are being controlled or monitored by external forces (Chadwick, 2002).

Fatherhood

The traditional Western view of the father is a man who is the biological progenitor of his child, living with the child and married to the mother. However, changes in society, with the increase in step-fathers, adoptive fathers and male guardians, have meant that new ways of defining fatherhood are required which take into account the increase in non-traditional fathering (Roggman, Fitzgerald, Bradley and Raikes, 2002). Fatherhood can be defined in terms of its functions, such as caregiving, teaching and providing support. It can also be defined in terms of a role which exists in a system, such as within a family or a community. The definition of father also varies across cultures and within cultures.

Fathering in the UK

Around 70% of UK families consist of children living with both their biological parents (Lewis, 2000). The 1992 round of the British Household Panel Study (BHPS) (Buck,

Gershing, Rose and Scott, 1994) was the first UK national sample survey to ask men of all ages about children they have fathered. A total of 4,350 men were interviewed, of whom 2,664 were fathers, with 1,379 of these men fathers of dependant children, defined as children under the age of 18. The data was analysed by Burghes, Clarke and Cronin (1997), who reported that 85% of fathers lived with all their children under the age of 18, while 13% of fathers of children under the age of 18 were not living with any of their children. Over 80% of fathers were married, while only 25% of men who were not fathers were married. 85% of fathers with dependant children aged below 18 were employed, in comparison with 71% of fathers whose children were all over 18 and 68.5% of men who were not parents. About one third of fathers became fathers for the first time when they were under 25, while around 40% of fathers had their first child at 25-29 years of age, which was the most common age for the onset of fatherhood. The review of the literature reported that both fathers and mothers spend more time caring for their children than previous generations of parents. Mothers still do the bulk of the childcare but fathers are doing more childcare than previously. However, as would be expected, fathers spend less time caring for their children if they have to spend more time at work (Burghes et al., 1997).

Unfortunately a great deal of the parenting literature is based on maternal parenting. There are many inadequacies with the research into fatherhood, such as the frequent tendency to define fathering in terms of activities identified with mothering, and the lack of research giving attention to the views of fathers themselves. There is lack of a common definition of fathers and fathering and there is insufficient knowledge of what

motivates fathers to be more involved with their children and what makes them less involved (Lewis, 2000; Roggman et al., 2002).

The experience of fathers

Clarke and O'Brien (2004) describe how the early research into fatherhood in the UK moved away from the mother-centred focus of previous parenting studies and used a *discovery* model, in which researchers sought to obtain a phenomenology of fatherhood and elicit more about the meaning of being a father. This research was accompanied by an idea that fathers should be studied as subjects in their own right and not as "alternatives to mothers".

In one of the key early qualitative studies of fathers in the UK, Lewis (1986) interviewed 100 men in Nottingham about the transition to parenthood. The participants in his study reported on their experience of fatherhood and numerous themes were elicited. There was an intensity of emotions accompanying fatherhood, which many of the participants found difficult to articulate. Becoming a father was associated with a sense of achievement and fulfilment, regardless of whether the child was their first or second. The majority of the fathers described care-giving to their children as rewarding and enjoyable. However, some fathers described times when they felt intensely hostile to their children, for example, when their sleep was disturbed. Some fathers were surprised by the depth of the emotions they experienced in association with the sense of responsibility they felt for their children, and there were also feelings of being "protective" of one's child.

Fatherhood appeared to change the outlook of the participants, with a sense that they were making a transition from their youth to a more mature and responsible adult status. Many of the participants felt that their social status had increased since they had become fathers, and they had also joined a new social network of parents, which previously wasn't open to them. Another important theme was that the fathers viewed their children as an investment for the future, and they were looking forward to their children becoming more successful in life than they had themselves. Other fathers were viewing their children as potential friends later in life (Lewis, 1986).

The findings from Lewis' study are limited because it did not have a random sample. Lewis interviewed only first or second-time fathers. He excluded fathers who were semi-skilled workers, unmarried fathers and fathers from first and second generation immigrant families. In addition, Lewis' analysis was inadequately described and there were no data or analytical audit procedures carried out by a second researcher.

In interviews with mothers, fathers, sons and daughters, Warin, Solomon, Lewis and Langford (1999) found that being the family provider was viewed as the central role of fatherhood. This view was especially prevalent in the interviews with fathers themselves. In contrast, the mother's main role was seen to be that of carer. Mothers doing paid work viewed their income as contributing to the family rather than providing for the family. In one family, this view was present in spite of the mother earning much more than the father. Fathers appeared to express their feelings of emotional attachment to their family via the role of provider. The fundamental nature of the provider role meant that fathers felt frustration, sadness and failure if they felt unable to provide

enough, due to unemployment or underemployment. The seemingly indivisible roles of fatherhood and provider also meant that men felt less confident as fathers if they were not earning money.

Besides providing, *being there* and *being involved* were seen as two core characteristics of the father role. *Being there* was associated with a sense of the father's commitment to the family and his availability should the family need to call on him for support. The teenagers in this study were more likely to go to their mother if they wanted to talk about problems, but nevertheless they valued having a father present. *Being involved* was associated with being psychologically available for the family. The mother's involvement was seen as the baseline against which the father's involvement was measured (Warin et al., 1999). Unfortunately, it is difficult to evaluate the analysis of this study because the researchers' descriptions of the analytical procedures are vague and incomplete. Any interpretation of the findings from this study must also take into account the fact that the researchers did not report any procedures to check the credibility of the data collection methods or the analysis.

In their exploratory study of paternal identity, Pleck and Stueve (2004) found that fathers construct their parental identity across many domains, such as caregiving and promoting development, in a manner which takes into account the relationship with their partners. The fathers appeared to have less of an independent parental identity, but viewed themselves as "co-parents". However, mothers do not do this to the same extent when constructing their maternal identity. The findings from this study may link with the research suggesting that mothers play a "gatekeeper role" in determining fathering

behaviour, with fatherhood often being expressed via the mother's determination of what the child needs (Pruett, 2000).

Silverstein (2002) reviewed the literature on fathering and found that there is support in current research for higher levels of positive paternal involvement being associated with positive outcomes for children. This involvement may have direct results such as the children having higher self-esteem and greater social skills, and there may be indirect results such as more positive interaction between siblings. The review described how research on fathering has changed over the years. Silverstein reports that certain researchers now propose that fathers have "a unique and essential role to play in child development". This is a contrast from the general views of researchers thirty years ago, who argued that mothers were essential and fathers were on the periphery in regard to having a role in child development. Silverstein stated that there has been a bias towards maternal attachment paradigms in the literature, and much more research is needed on fathers and the effects of fathers on their children.

Silverstein (2002) reports that much of the literature on fathers is of poor quality because it is often derived from studies which were not designed from the outset to investigate fathers, but instead to answer research questions from other areas of inquiry. In discussing future directions for research on fathering, Silverstein advocates for a commitment to qualitative research paradigms, because such methods are useful in generating hypotheses for populations about whom relatively little is known.

Effects of fathering

Parke, Power, and Gottman (1979) developed a pioneering theory that fathers have a significant indirect effect on the child through their relationship with the child's mother. More recently, McHale, Lauretti, Talbot, and Pouquette (2002) reviewed the data on family group dynamics within the child and family development literature. They found support in the research not only for the importance of marital relationship dynamics and dyadic parent-child dynamics but also family group processes at a system-level and they argue for more research examining parent-child relationships in the context of family group processes.

The research literature has identified two main patterns in which two parents jointly parent a child or "coparent". One pattern is antagonistic, hostile and competitive with an imbalance between the two parents in terms of engaging with the child. The other pattern of coparenting involves cohesion, cooperation and child centredness. In families where the parents are experiencing marital conflict, the first pattern is more common, with hostile-competitive coparenting and imbalances in mother-father involvement with the child taking place. In addition, when there is marital conflict, fathers are more likely to continue their involvement with their sons but withdraw from their daughters, which may be linked to men's beliefs that they can make an important and unique contribution to the socialisation of their sons (McHale et al., 2002).

McHale et al. (2002) suggest that the literature points towards the presence of system-level processes operating within families, which have unique effects, separate from traditional marital or parent-child relationship dynamics. For example, McHale and

Rasmussen (1998) found that a statistically significant proportion of the variance in child outcome measures is explained by family group indices. This study also found that infant children of parents who coparent in a hostile-competitive pattern are later rated as being more aggressive by their teachers.

McHale et al. (2002) argue that parenting behaviour differs depending on the context. A parent interacting with the child in a parent-child dyad behaves differently to a parent interacting with that child in a family context such as within a parent-parent-child triad. When there is marital conflict, there is an increase in the difference between how the child is treated in a dyad with a parent, and how the child is treated in a family setting by that same parent. When compared with fathers and mothers in marriages without conflict, mothers in a distressed marriage display a greater decline in responsiveness to their children when moving from dyadic to family contexts while the fathers in a distressed marriage show a decline in engagement with their children when moving from a dyad to a family setting. There is therefore greater inconsistency in the parenting children receive when their parents are having marital problems. For young children, the associated lack of predictability about the quality of one's parenting may be particularly disruptive (Lauretti and McHale, cited in McHale et al., 2002).

It is possible that children develop conceptions of their family group, in addition to the parent-child attachment patterns. McHale, Neugebauer, Asch and Schwartz (1999) have found associations between the narrative style of young children describing family conflict and their mothers' ratings of family conflict.

Pruett's (2000) book, in reviewing fatherhood research, argued that families have a "fatherneed" and this need is expressed by mothers as well as children. There are unique qualities to the care provided by fathers which at its core comprises: "...feeling and behaving responsibly towards one's child, being emotionally engaged, being physically accessible, providing material support to sustain the child's needs and exerting influence in child rearing decisions". The care from a father is different from that of the mother. For example, father play is of a different quality to play with the mother, involving more physical activity and exploration for novel stimuli. Pruett argued that there are enduring benefits from fathers being present in their children's lives and there are critical periods to the father-child relationship, e.g. birth, beginning school, illness, divorce.

Pruett suggested that the event of becoming a father is preceded by numerous experiences which contribute to the paternal style, the most prominent of which is probably the father's own experience of growing up in his family of origin. Having a positive paternal role model in one's own father is an important factor in the development of a father's ability to become an involved, authoritative parent. However, for some men, there is a process of "reworking", in which their fathers were experienced as inadequate or abusive parents, and there is a desire to rework or compensate for the early negative experiences by becoming better fathers to their own children (Pruett, 2000).

Pruett also reports that new fathers may feel anxious about being able to protect their family from harm. They may feel vulnerable, inept and uncertain about how to go about caring for the child. Pruett argues that new fathers can experience a dilemma of

providing vs. childcare, in which they want to provide for the child and secure the child's future, which entails harder and longer work away from home in order to earn more, and yet they have a desire to be more involved in caring for the child. Pruett states that the resolution of this dilemma is influenced by a range of fatherhood models, which are not drawn from any specific individual but compiled over time into an individual concept of what a father should be. Pruett argues that fathering needs to be viewed in the context of a co-parenting relationship with the partner. There is a continuing need for support from the partner in order for parenting to be effective. Becoming a father can have enduring positive effects on men, such as increased sense of responsibility and a greater sense of competence. This report by Pruett was limited in that many of the arguments were not presented alongside relevant evidence. The research studies which were included in Pruett's report were not described in sufficient detail, and as a result it is impossible for the reader to evaluate the arguments of the author.

Attachment

Attachment theory (Bowlby, 1969, 1973, 1980) proposes that a child's parents provide a secure base from which the child can explore the world and then return. The parents are conceptualised as attachment figures. Early attachment experiences in the first years of life are internalised and held into adulthood, influencing later interpersonal relationships.

Ainsworth, Blehar, Waters and Wall (1978) classified attachment into three patterns: *Secure*, *Insecure-avoidant* and *Insecure-resistant/ambivalent*. *Secure* infants who are separated from a parent and left in a strange, unfamiliar situation, are distressed by the separation, but confidently and effectively seek comfort when the parent returns.

Insecure-avoidant infants do not acknowledge that they have been separated from the parent and they ignore the parent when she returns. *Insecure-ambivalent* infants are distressed by the separation but behave fussy, angry and resistant to the parent when she returns. A fourth pattern was later introduced, and labelled *Disorganised*, because some infants were found to display behaviours in which *Insecure-ambivalent* and *Insecure-avoidant* attachment patterns occur at the same time (Main and Solomon, 1990). For example, an infant might bring one part of the body close to the parent while turning away at the same time.

In these studies, the mother is viewed as the primary attachment figure in an infant's life. However, the importance of infant-father attachment is being increasingly recognised. In one study, infant-mother attachment was predicted by the mother's Adult Attachment Interview while the infant father relationship was independently predicted by the father's interview. Therefore, the research concluded that the infant develops a relationship to the father independent of the relationship to the mother (Steele, Steele and Fonagy, 1996). However, there were certain limitations to the generalizability of findings from this study. For example, the participants came mainly from middle-class families, the parents were all cohabiting at the beginning of the study, and while infant-father attachment was assessed at 18 months, infant-mother attachment was assessed at 12 months. The infants in the Swedish study of Lamb, Hwang, Frodi and Frodi (1982) who were securely attached to their fathers were the most sociable with strangers. However the sociability of infants was not associated with the security of the infant-mother attachment. This is evidence that infants form different kinds of relationship with their fathers than they do with their mothers. However it is noted that the researchers were

unsure why these results were obtained, and they speculated that there were cultural influences on the patterns of infant-parent interaction in the study, which affected the generalizability of the findings to other cultures.

Parents with serious mental illness

Much of the research into parents with psychosis is in the form of studies of parents with serious/severe mental illness. This section therefore reviews this body of literature.

Serious mental illness (SMI) is usually defined in the literature as long-term and persistent mental health problems, including schizophrenia and related disorders, and major affective disorders such as depression, in which the patient has required intensive service input for more than one year (Mowbray, Oyserman, Zemencuk and Ross, 1995).

It is important to differentiate between women with a puerperal mental illness, where the onset is within two to four weeks of delivery, and women who already have an SMI before they have children (Mowbray et al., 1995). This literature review focuses on the latter group.

The change from institutional care to community care has been associated with an increase in the number of people with serious mental illness who become parents (Mowbray et al., 1995; Miller, 1997; Oyserman, Mowbray, Meares and Firminger, 2000). Having an SMI does not necessarily make a person relinquish the desire for the socially common goal of becoming a parent, and parenting can be viewed as one way of attempting to achieve greater satisfaction with one's quality of life in the midst of the

chaos and abnormality associated with mental illness. The desire to become a parent is a powerful, natural human instinct (Apfel and Handel, 1993).

The use of the older, “typical” antipsychotic medications inhibited the fertility of many women with psychosis. However, the newer “atypical” antipsychotics, such as Clozapine, are not associated with such a reduction in fertility. Therefore as more female patients with psychosis are prescribed the newer drugs, the rate of pregnancy amongst this population is expected to increase (Empfield, 2000). However, there is debate as to the risk to the foetus from antipsychotic medication (Mowbray et al., 1995).

Demographics of parents with SMI

In the UK in the early 1990’s, the prevalence of functional psychoses in couples with children was 4 per 1000 (0.4%) while the prevalence of functional psychoses in single parents was 11 per 1000 (1.1%) (Meltzer et al., 1995). There are therefore many children living with psychotic parents. Women with serious mental illness are more likely than mentally well women to have unplanned children and to give birth while unmarried and then parent without the support of a partner. They are likely to have children at an early age, when they are less prepared for becoming a parent (Zemencuk, Rogosch and Mowbray, 1995; Miller, 1997). A lack of education about birth control may be a major influence in women with SMI having unplanned children (Mowbray et al., 1995).

The effect of serious mental illness on the experience of parenting

Parents with mental illness have a range of experiences. Some have no problems in managing child care and their illness, others have a great deal of difficulty parenting and their children have to be taken into care.

Reduced capacity to meet the demands of parenting

Having a psychiatric diagnosis has been shown to be associated with inadequate prenatal care, which has negative effects on the health of both the mother and infant. However, it is uncertain as to why this is the case. Mothers with mental illness may have a poor social support network or they may be more likely to have an unwanted pregnancy and consequently delay in seeking care. It has been suggested that some mental illnesses may affect one's motivation for care or belief in the benefit of care (Kelly, Danielsen, Golding, Anders, Gilbert, and Zatzick, 1999).

Many parents with mental health problems feel that mental illness undermines their parenting skills. Parenting can become episodic, and the ability of a person to fulfil the parental role can be lost without warning. For example, mental illness can lead to neglect, such as forgetting to bathe the children for several days. Mental illness might cause parents to lose their temper more easily with their children, because they feel more irritable. When mental illness leads to a parent's long-term incapacity or loss of ability to function as a parent, the children can become more vulnerable to developmental delay, neglect or other risks. This is because the parent may not be as sensitive to the

needs of the children, because the mental illness makes them emotionally “absent”.

(Thomas and Kalucy, 2002; Aldridge and Becker, 2003).

Thomas and Kalucy (2002) interviewed 35 Australian parents with SMI in a qualitative study on the effects of mental illness on the families of parents with SMI. The findings of Thomas and Kalucy (2002) are limited by the absence of validity checks other than reviewing and discussing the findings with two of the mental health service users who had been involved in the development of the study. In addition, the researchers themselves admitted there was no clear theoretical basis in the development of the questions or to guide the analysis of the participants’ transcripts. The study of Aldridge and Becker (2003) involved the interview of parents with SMI, children caring for these parents, and service professionals involved with families where a parent has an SMI. The report of the study is seriously limited by absence of any description on the analytical methods used or any description of validity or reliability checks. In addition, the care project workers selecting the potential participants on behalf of the researchers did so using personal and professional judgements about the “suitability” of participants, or their ability to withstand the stresses of interview. However, many conclusions were grounded with excerpts from interview transcripts.

Medication side-effects

The side effects of medication may include tiredness and loss of energy, compounding the stress of parenting. A parent may then find it difficult to balance her own mental health needs with the needs of her child. For example, a mother with a mental illness may decide not to take her medication so that she has more energy to care for her

daughter. Alternatively, she might be worried that her antipsychotic medication will have a powerful sedative effect and she will not hear her infant's cries during the night, and so she will not take the antipsychotic (Nicholson, Sweeney and Geller, 1998a; Empfield, 2000).

Difficulty in managing stress

It can be difficult to handle the stresses of parenting as well as the direct and indirect stresses of mental illness. Parents with serious mental illness may have poor adaptive living skills (Empfield, 2000). Parents may have to care for their children, a stressful job in itself, while maintaining their treatment regime, attending appointments with mental health services, and coping with auditory hallucinations. They may find it difficult to manage their children's behaviour and tolerate the inevitable frustration with their children. Sometimes, mothers with mental illness may find it difficult to identify the origin of stressful feelings and they do not know whether it is their mental illness or the child care which is the source of the stress. Mothers with mental illness may evaluate themselves unfairly in fulfilling the parenting role. They may blame themselves for problems with their children's behaviour which are actually a normal part of childhood development (Nicholson et al., 1998a). Parents with mental illness may be more vulnerable to relapse because of the added burden associated with child care. The diathesis-stress model (Zubin and Spring, 1977) proposes that individuals have different levels of vulnerability to developing a mental illness. The model suggests that mental illness develops through a combination of stress factors and vulnerability factors. For a given amount of stress, a more vulnerable person will be more likely to develop a mental disorder than with a less vulnerable person. Parenting can be a source of great stress,

which combined with a parent's vulnerabilities to psychosis (such as brain structure and genetic heritage) can trigger a deterioration to a psychotic mental state.

Parents may be especially stressed by caring for children with special educational needs, behavioural problems or physical disabilities (Nicholson et al., 1998a).

When parents have an SMI, the stresses of parenting need to be managed at the same time as the mental illness (Nicholson et al., 1998a). A parent might miss an important appointment with their mental health professional because she has to look after her child (Empfield, 2000). The emotions expressed by the family of a parent with SMI can have a powerful influence on their mental state. One way in which this may occur is via expressed emotion. Expressed emotion can act as the stressor which adds to the parent's vulnerability, leading to a relapse in the parent's psychotic illness. Expressed emotion has origins in the research of the 1950's. It reflects the negative or intrusive attitudes that relatives of an individual with schizophrenia express about that individual, and it is assessed by means of a family interview (Vaughn, 1989). One review of 26 studies found that a high level of expressed emotion in a family is associated with a median relapse rate over 9-12 months of 48%, as compared to a 21% rate for low expressed emotion (Kavanagh, 1992).

Communication problems

In one study, schizophrenic patients were shown to have difficulties in their perception of subtle, abstract social cues during a social cue recognition task (Corrigan and Green, 1993). This may indicate that people with schizophrenia have reduced social cognition skills. Parents with a deteriorating mental state may become "emotionally absent" from

their children (Aldridge and Becker, 2003). One study found that mothers with schizophrenia were withdrawn and emotionally uninvolved with their children and have “lower quality parenting” than either depressed mothers or mothers with no mental illness. It was argued that the diagnosis of each mother influenced the quality of the parenting, which in turn influenced the children’s intellectual and social functioning (Goodman and Brumley, 1990). Among mothers who have experienced hospitalisation for mental illness, insight into mental illness has been shown to be associated with more sensitive mothering behaviour (Mullick, Miller and Jacobsen, 2001). Mothers with mental illness may not know how to talk to their children about the illness, and they might benefit from advice and support in doing so (Nicholson et al., 1998a).

Parents with SMI may prefer to withdraw from society, which may lead to the parent and the children experiencing isolation. There are many possible explanations for this need to withdraw. For example, the illness may lead to a lack of motivation to go outdoors, the illness may cause a parent to feel that it is unsafe to leave the house or the children may feel they have to stay at home to look after their parent. Within the family, there may be poor communication between family members leading to a lack of knowledge about others in the family. Family members may conceal problems from the parent with mental illness in order to protect him or her, while at the same time the parent may withdraw from other members of the family because of the illness (Thomas and Kalucy, 2002).

Separations from family due to hospitalisations

Being hospitalised and separated from the family is often a major concern for parents with mental health problems and their families. The length of the stay in hospital is often uncertain, and families may worry that the separation will be permanent (Aldridge and Becker, 2003). Hospitalisations can strain family relationships, with the parents experiencing both anger and sadness from their family. There may be anger that the parent has become mentally unwell again, there may be sadness that the parent has to leave home to go to the hospital. Children may fear that their parent will never come back. Sometimes, the children may behave distant or withdrawn from the parent who has returned home after a stay in hospital. This may be due to the separation itself, a fear that the parent will become unwell again and go back to hospital, or a lack of understanding about why the parent had to go away. Children may not realise that mentally ill parents are often unable to control their illness, despite their best efforts, and they may then blame the parent for their absence from home (Thomas and Kalucy, 2002).

On a functional level, a hospitalisation may be minimally disruptive because the mentally well partner will be responsible for much of the running of the family and home even when the partner with mental illness is at home. Nevertheless, when a mentally ill parent is hospitalised, meals may not be prepared, bills may be left unpaid and clothes may not be washed (Thomas and Kalucy, 2002).

In a single parent family where the parent has mental illness, the effect of a hospitalisation may be especially traumatic. With a limited social support network and declining mental health, the concern about who will look after the children during the

impending hospitalisation may increase the parent's distress (Bassett, Lampe and Lloyd, 1999). A socially unsupported, isolated parent may have to decide between caring for her child and going into hospital, potentially precipitating a crisis situation.

Unfortunately, such a crisis may result in the removal of the child from the parent's care, which is often the greatest fear of a parent with mental illness (Nicholson et al., 1998a).

While the mentally ill parent is in hospital, the families at home may receive little or no extra support from professionals, and they may not be made aware of the management and progress of their loved one's treatment. There is a need for services to be doing this type of work. When a family visits the mentally unwell parent in hospital, there may be a concern about exposing children to a psychiatric ward with many distressed and unsettled patients and a lack of privacy for visiting family. The children may find the psychiatric ward distressing. Sometimes the hospital may be some distance from home, which can make visits time-consuming and costly (Thomas and Kalucy, 2002; Aldridge and Becker, 2003). Because of these issues, the effect of the loss of contact caused by a hospital stay may be compounded because the children are unable to visit frequently (Aldridge and Becker, 2003).

In hospital, the inevitable institutionalisation and lack of activity may mean that the parent is not being prepared to return home and begin to parent again. Once the parent has returned home, it may take several weeks before they are able to contribute to the family at an equivalent level to what they did prior to the relapse. Everyday tasks such as cooking, washing and shopping may have to be relearned. Families may benefit from

special post-hospitalisation services, such as extra appointments with keyworkers (Thomas and Kalucy, 2002).

The effect on the children

Oates (1997) argued that children may be at great risk if their parents have a psychotic episode and that parents with mental disorders are less likely to be emotionally responsive to their children and more likely to neglect the needs of their children. It is acknowledged that children living with a mentally ill parent often have negative experiences. The lower maternal responsiveness and emotional involvement in mothers with mental illness may adversely affect their children's social functioning (Goodman and Brumley, 1990). Parents with SMI may have a lack of interaction with their children, sometimes to the point of neglect (Thomas and Kalucy, 2002). Children may worry that the parent will commit suicide or harm themselves. They may not understand their parent's mental illness. This is sometimes because the children are seen as too young to understand, and so it is not discussed with them. Sometimes it is because the parent is reluctant to tell the children about the illness. This may occur when the parent is well and prefers to pretend that the illness has "gone away" (Thomas and Kalucy, 2002). Sometimes, parents with mental illness may use alcohol or street drugs in an attempt to cope with their mental illness. However, it must be noted that there is no adequate evidence that children are at risk of neglect or serious harm or abuse on the sole basis that they have a parent with a mental illness. The age of the child may be a protective factor as school age children have a wider social and educational network (Aldridge and Becker, 2003).

Parenting can become episodic or intermittent, with unpredictable losses of parenting functioning, and separations from the child. A young toddler with high practical and emotional needs may be greatly affected by a parent's mental illness (Aldridge and Becker, 2003). Separations from the family often occur in the SMI population. In one study of mothers with SMI (schizophrenia, schizoaffective disorder or major affective disorder) less than half of the participants had lived with both parents during their childhood. Nearly one-third of the participants had been separated from their own mothers at some point before they reached adolescence. The reasons for these separations included going into foster care, being sent to live with relatives and the hospitalisation of the participant's mother. This may mean that these individuals did not grow up with adequate parental role models (Zemencuk et al., 1995).

Psychosis undermines attachment

Hill (1996) argues that a psychotic parent who is experiencing delusions and fears will have less capacity available to attend to their children sensitively, and to anticipate their needs. This may have implications for the attachment relationships of their children, as the research indicates that children with more responsive parents are more securely attached as one-year olds (Ainsworth, Bell and Stayton, 1971). Mothers with nonorganic psychosis have been found to have increased tension and uncertainty, diminished social contact with the infant and reduced sensitivity to its needs, which probably affect the development of attachment in the infant (Persson-Blennow, Naslund, McNeil, and Kaij, 1986). An associated study found a significantly increased rate of anxious attachment has been found for the one-year old children of women with nonorganic psychosis

(Naslund, Persson-Blennow, McNeil, Kaij, and Malmquist-Larsson, 1984). Therefore, psychosis may preclude many of the essential elements of attachment.

The attachment relationship is important because it may be implicated in the child's vulnerability to developing mental health problems later in life such as depression, antisocial personality disorder and psychosis (Hall, 1996; Bentall, 2003). A parent experiencing a psychotic episode may misattribute intent and meaning to a child's behaviour and in so doing, their attachment relationship and their parental function is completely undermined. However this is not to say that a parent will not be committed to maintaining attachment with their child and take efforts to minimise the risk of relapse. Avoiding contact with the children if relapsing might be one way in which a parent tries to maintain a secure attachment relationship (Hill, 1996).

The child's understanding of the illness is a critical factor in the maintenance of attachment. If a child recognises that when their parent is unwell, that they will behave differently towards them because they are absent from themselves, this may help protect the attachment. Alternatively, a child may experience a parent's mental state during a relapse as a part of that parent's identity. This must then be incorporated along with their perception of the parent when he or she is not psychotic. The extent of the disruption to the attachment relationship which arises from psychosis, may depend on the child's ability to make sense of the changes in their parent's mental state, together with the parent's understanding, the family's understanding and the education provided by professional services. However, it is possible for parents to retain a sensitive contribution to the attachment relationship even though they experience psychotic

symptoms, or they may lose their sensitivity even though the psychotic symptoms diminish (Hill, 1996).

When the parent-child roles are reversed, and the child becomes a parentified carer of the parent, there is potential risk of an attachment disorder. However, it is possible that this is only a danger when a child takes on a long-term, disproportionate parentified role. If the parent ceases to parent for a limited time, the undermining of the parent-child relationship and the child's development is less likely to occur. Many parents do not intend to place unfair burdens of care onto their children, however it is sometimes done out of necessity (Aldridge and Becker, 2003).

Experience of stigma and discrimination

In a survey of 1,300 mental health consumers in the USA, and in-depth interviews with 100 of these participants, Wahl (1999) investigated experience of stigma and discrimination among the mentally ill. Seventy-four percent of the survey respondents reported having been advised to lower their expectations in life because they were consumers of mental health services. Over half of those in the survey said that they had felt that others had avoided them at some point, and seventy-four percent of respondents said they had at some point avoided telling others outside their immediate families about their mental illnesses. In the interviews, ninety-five percent of the participants said that there had been long-term consequences to stigma experiences. There is evidence that stigma is not limited to the mentally ill person alone. For example, Phelan, Bromet, and Link (1998) examined experiences of stigma in 156 parents and partners of first-

admission psychiatric in-patients. Half of the participants reported that they had in some way concealed the fact that their relative had been admitted to hospital.

Mothers with mental illness might feel that they will be treated differently and people will avoid them and their children if others find out that they have a mental illness (Bassett et al., 1999). Parents with mental illness may experience discrimination in local communities leading to them feeling socially isolated and marginalized (Aldridge and Becker, 2003). The stigma of mental illness may involve assumptions that mothers with mental illness cannot care for their children. There may be negative views even if a woman with mental illness is contemplating becoming a parent. Pregnant mothers who have a mental illness may fear that their children will be taken away into foster care after they are born. They may not feel comfortable talking with service professionals about their pregnancy, and then unnecessarily stop taking medication for their mental illness out of a fear of harming their baby, with a resulting deterioration in their mental health. As a result of stigma, mothers with mental illness may feel that they have to prove themselves to be adequate parents. This can act as a motivation to try harder as a parent, or it can discourage someone from trying at all. There is the fear that any problems with the children, even normal adolescent issues, will be blamed on the parent's mental illness. In connection with the stereotype of the mentally ill as violent, there may be an assumption that mothers with mental illness will abuse their children (Nicholson et al., 1998a).

Ackerson's (2003) qualitative study involved the interview of thirteen parents who had either a psychotic disorder or a major mood disorder. Twelve of the parents were

women, only one of the parents was a man. The parents reported an experience of stigma which made them less willing to seek help from services, fearing that they would lose custody of their children. They also reported that their children were victims of discrimination at school as a result of their parent's mental illness. In another study, it was suggested that mothers with mental illness may require guidance as parents, however they may be reluctant to seek such help because of the stigma associated with having a mental illness (Sands, 1995). With regard to the children, it has been suggested that children may experience "stigma by association" because their parent has a mental illness. For example, children may be bullied or taunted because they have a parent with mental illness. Children may consequently be motivated to conceal their parent's illness from others (Aldridge and Becker, 2003).

Difficulties with interpersonal relationships

Mental illness can contribute to difficulties parents experience in their relationships with their partners (Ackerson, 2003). For example, the unpredictability of mental illness can contribute to the breakdown of a relationship. The burden of care that individuals with SMI place on their families has been well-documented (Webb, Pfeiffer, Mueser, Gladis, Mensch, DeGirolamo and Levinson, 1998; Jenkins and Schumacher, 1999; Johnson, 2000). In families where the mother has mental illness, the increased burden of care and responsibility placed on a male partner may be especially likely to lead to the deterioration of the marital relationship because of the importance of the mothering role (Aldridge and Becker, 2003).

Conversely, the mental health of mentally ill parents may deteriorate if they experience relationship problems with their partners. If the relationship subsequently breaks down, the effect on their mental state may be especially damaging. Later, following a divorce or separation, coping as a single parent can be especially difficult for parents if they suffer from poor mental health (Thomas and Kalucy, 2002; Ackerson, 2003; Aldridge and Becker, 2003).

Adults with SMI may require help from a social support network in order to cope with the daily tasks of living. Mothers with SMI who feel that their social network gives them emotional support view themselves more favourably. This in turn contributes towards their sensitivity as parents (Rogosch, Mowbray and Bogat, 1992). However, it should be noted that the participants in this study were sectioned inpatients and they were mostly of lower socio-economic status. A lack of support in the event of life stressors can have a negative effect on one's mental health (Creswell, Kuipers and Power, 1992). If these adults have children, it may present the support network with a "double burden" of care (Gamache, Tessler and Nicholson, 1995). Many parents with psychosis rely on relatives or friends to help them with childcare (Hearle, Plant, Jenner, Barkla, and McGrath, 1999). However, many people with serious mental illness find it difficult to establish social relationships and their social networks may be small (Creswell et al., 1992; Nicholson and Blanch, 1994). Sometimes this is because they wish to conceal their illness from others because of stigma (Aldridge and Becker, 2003). Some evidence suggests that on average, mothers with mental illness have smaller support networks than mentally well mothers and these networks are mainly made up of relatives (Zemencuk et al., 1995). However, they may be single parents with few family or

friends to support them, and they will consequently feel socially isolated. They may have to heavily rely on professional childcare services and child care can be particularly difficult at weekends, when professional support services reduce their staff or close (Bassett et al., 1999).

Poverty, unemployment and inadequate housing

The link between poverty and mental health problems is well established (Belle, 1990). In one study, 46% of mothers with mental illness reported that their finances were inadequate to provide for the needs of their families; 85% had been employed at some point in the past, but only 13% had been in employment at the time of their most recent hospitalisation (Zemencuk et al., 1995). Parents with mental illness may be living only on financial support from the government (Aldridge and Becker, 2003). They may have reduced financial capacity to pay for childcare services, which can make it more difficult to access professional child care (Hearle et al., 1999). Continued unemployment may help perpetuate serious mental illness, which in turn may make it more difficult to obtain employment, a vicious cycle. As with mentally ill people in general, parents with mental illness may be discriminated against when looking for work (Aldridge and Becker, 2003). Parents with SMI may not be able to find affordable accommodation. They may live in areas where they feel it is unsafe for their children to live (Sands, 1995; Zemencuk et al., 1995). They may live in rented properties which are too small for the size of their families (Aldridge and Becker, 2003).

Fear of losing custody

Several authors (e.g. Schwab, Clark and Drake, 1991; Perkins, 1992; Sands, 1995; Bassett et al., 1999; Aldridge and Becker 2003) have discussed the effect of loss of custody of children and the fears associated with this. These are not baseless fears. For example, the survey of Hearle et al. (1999) involved 48 parents with psychosis who had children under 16. Only 20 of these parents still had their children living with them. Many of the mentally ill mothers in the study by Sands (1995) had experienced their children being taken into care by social services because of neglect, incapacity or substance abuse. Cogan's (1998) qualitative study of twenty-five women with serious mental illness found that stigma about mental illness influenced child custody decisions. The mothers felt that they were "guilty of incompetence unless they could prove otherwise". Anxiety about the possibility of losing one's children may be a contributing factor in the relapse of mental illness for some parents. This anxiety may also affect recovery (Nicholson et al., 1998a). Parents with psychosis may be afraid to access childcare services, fearing that they might somehow lose custody of their children because professional services will not respect their needs as parents (Hearle et al., 1999). If a parent does lose custody, this may not mean a loss of contact with the children. However, each visit with one's child will be accompanied by another separation, which is a very painful experience (Nicholson et al., 1998a).

Fear of children inheriting mental illness

Not without reason, parents with mental illness sometimes fear that their children will inherit their genes for mental illness (Bassett et al., 1999; Nicholson et al., 2001). Some parents may be concerned that their children will assimilate their behaviours or

emotions, for example, becoming low in mood like their parent, or having ideas of injuring themselves (Aldridge and Becker, 2003).

Malaspina's (2001) review indicates that there is a strong genetic component for schizophrenia risk and she proposes that individuals with schizophrenia may be those with older fathers, who are a major source of new genetic mutations. However, the most prominent support for the genetic contribution to schizophrenia comes from The Finnish Adoptive Family Study of Schizophrenia. In this ongoing study, offspring of schizophrenic women who had been adopted by nonrelatives during their first 4 years of life were compared with matched controls, who were adopted-away offspring of biological parents who have not been hospitalised for psychosis. The report of 1990 compared 128 index offspring with 128 control offspring, and it was found that 10 of the index offspring had developed psychosis in comparison with only 1 of the controls (Chi square = 7.694, $p = .005$). The total percentage of severe diagnoses, which were defined as psychosis, borderline syndrome, and severe personality disorders, was 28.1% in the index group and 15.6% in the control group (Tienari, Lahti, Sorri, Naarala, Moring, Kaleva, Wahlberg, and Wynne, 1990).

A later report from the Finnish adoptive study found that adoptees whose mothers had schizophrenia had a mean lifetime, age-corrected morbid risk for narrowly defined schizophrenia of 5.34% (SE = 1.97%). This was compared to 1.74% (SE = 1.00%) for low-risk adoptees. This was calculated to be a marginally nonsignificant difference. However, in analysing adoptees whose mothers had schizophrenia spectrum disorders, the mean age-corrected morbid risk for a schizophrenia spectrum disorder was 22.46%

(SE = 3.56%), compared with 4.36% (SE = 1.51%) for low-risk adoptees, a significant difference. The researchers conclude that there is the possibility of "...a low-level multifactorial liability, dispersed across the broad range of disorders found in the offspring of mothers with typical schizophrenia, but also found collectively in the ...sample of offspring of mothers with other disorders in the broad schizophrenia spectrum" (Tienari, Wynne, Laksy, Moring, Nieminen, Sorri, Lahti and Wahlberg, 2003). It is important to note that the findings from studies indicate a *liability* to schizophrenia as a result of one's genes. Many factors, such as the childhood environment, are possible contributory factors in the development of schizophrenia.

Lack of support or understanding from services

Some professional services of parents with SMI often do not consider parenting issues with their patients and official clinical documents may not mention the patient's children (Mowbray et al., 1995). Other services may have a pathological view of their patient's lives, which may extend to their desire to have children (Apfel and Handel, 1993). The services may be guided by concern over risk, especially to the child, ignoring the positive benefits to the patient of becoming a parent. Fox wrote about her experience of being a mentally ill mother of four. She felt that mental health services had not prioritised her role as a mother and consequently she felt unsupported in caring for her children. She reported that this lack of support meant that life was a dichotomy where she either lost custody of her children when her mental state deteriorated, or she was completely responsible for their care. She argued that professionals should not view parenting and mental illness as "mutually exclusive" and that ongoing family treatment should be part of every care plan for mothers with a mental illness. These plans would

include strategies to develop parenting skills, communication skills, problem-solving skills and the ability to manage stress (Fox, 1999).

The effect of parenting on the experience of serious mental illness

The experience of being a parent can often have a positive effect on individuals with SMI, for example, providing one with a sense of pride, enjoyment and motivation to recover from mental illness. However, parenting does have drawbacks, such as the stress associated with the raising of children.

Pride in being a parent - A valued social role

Mental illness may cause people to lose their sense of identity and to feel that they *are* the illness. They may consequently relinquish control over their lives and let others take responsibility for them (Deegan, 1993). However, parenthood may provide people with a sense of identity which counteracts this loss. For example, mentally ill mothers may view motherhood as a life experience which has a central place in their lives, one which gives meaning and focus to their existence (Sands, 1995).

Mothers with serious mental illness can receive positive and motivating effects from their role as parents. The role of parent is likely to be central to one's sense of self and is often a valued status. Therefore to feel successful as a parent will give one a sense of self-worth and competence. However, failures in this role may feel especially damaging and stressful to parents with mental illness. Motherhood can motivate mentally ill mothers to remain involved with mental health services (Oyserman et al., 2000). Parents

with mental illness may feel that they share a “common bond” of parenthood with each other, which can give them a sense of belonging to a valued group. People with mental illness may feel they have been treated as children by social services, mental health services and the law. Becoming a parent may be the first time they have been treated as adults (Schwab et al., 1991).

Motivation to deal with the mental illness and recover

Recovery from mental illness is associated with self-empowerment. This involves developing attitudes of self-confidence, patience, determination and courage. It also involves one’s behaviours, such as being proactive, confronting problems and ceasing destructive habits (Young and Ensing, 1999). It must be noted that the study of Young and Ensing was limited by a very small sample of 18 participants, comprising a wide range of mental health problems, including psychotic disorders, personality disorders and mood disorders. The sample was thus extremely heterogenous, which limits the generalizability of the findings. It is argued that in the process of fulfilling the parenting role, people with SMI will become self-empowered, and thus to some degree recover from their illness. Parents may experience their children as a motivation to recover from their illness. Being responsible for children may motivate a parent to seek help because they know that they will not be able to care for their children unless they also care for themselves (Nicholson et al., 1998a; Oyserman et al, 2000). Living with one’s children and having their emotional support may help prevent episodes of self-harm, or even suicide attempts (Aldridge and Becker, 2003). However, it must be remembered that there is the potential with these parents to place their children before their own mental health (Nicholson et al., 1998a; Bassett et al., 1999).

The enjoyment of being with one's child

The experience of raising children can raise the self-esteem of parents with serious mental illness (Ackerson, 2003). For mothers with mental illness, it can be a pleasurable experience to live with their children (Sands, 1995). Parents can have strong and effective relationships with their children in spite of their mental illness, especially if the parent acts to “shield” the child from the worst aspects of the illness (Aldridge and Becker, 2003).

Support from partner and children

In many families, the partner of the parent with SMI assumes the majority of the responsibilities for the family. Partners may provide financial support, child care, maintenance of the home. They may also take responsibility for a family's interaction with the community, including tasks such as shopping and paying the bills. In addition these partners may help the parent with SMI to manage their illness and provide them with a comforting sense of safety and security (Nicholson, Sweeney and Geller, 1998b; Stromwall and Robinson, 1998; Judge, 1994; Green, 2003). However, the married partners of mothers with schizophrenia have high rates of mental health problems, which may make it more difficult for them to provide support (Miller, 1997).

Parents can often benefit from their children's support. In one study, 77% of mothers with serious mental illness listed their children as providing support (Zemencuk et al., 1995). Children can provide immediate and consistent support because they live with their parents. However, there is a danger when a child is made to take on a parentified role in which the parent-child roles are reversed. Children can provide a different, and

sometimes better quality of support than that from a partner, for example, if the partner is often away at work. A single mother with a limited social support network may find herself increasingly relying on her child to care for her and support her because there is simply no one else available. The act of caring for the mentally ill parent may strengthen the parent-child bond provided the need for care from the child is not chronic in nature. Caring can actually be a positive experience for the child of a mentally ill parent (Aldridge and Becker, 2003).

The present study

The literature on parents with serious mental illness has concentrated on mothers. For example, Ackerson's (2003) qualitative study involved the interview of twelve mothers and only one father while Bassett et al. (1999) studied only single mothers. A major review of parenting amongst individuals with serious mental illness focused solely on mothers (Oyserman et al., 2000). The reviewers acknowledged the disregard of fathers in studies of parents with SMI, and they argued that this disregard was justified because women with SMI are more likely to become parents than men with SMI. However, one group of researchers have suggested that fathers with SMI are a substantial population, that they have needs similar to other fathers, and by supporting these men in their parenting role, services can have a significant positive impact on the quality of life of the fathers and their children as well (Styron, Pruett, McMahon, and Davidson, 2002). There are probably many fathers with SMI. For example, Nicholson, Nason, Calabresi, and Yando, (1999) found that around 20% of men with SMI report they have children. Caton, Cournos and Dominguez (1999) found that there were 47 fathers within their

sample of 200 men with chronic schizophrenia. Styron et al. theorised that the parenting role “may promote a sense of competence and give meaning to their lives”. If the fathers in this population have lost contact with their children, Styron et al. hypothesised that reunions might have positive benefits to the men’s sense of self-worth, although there are dangers of the men feeling ashamed and inadequate and also the children might reject them. It was concluded that there is “an urgent need” to research this population more thoroughly (Styron et al., 2002).

There are several possible reasons why the population of fathers with mental illness has not been investigated to the same extent as other groups. Phares’ (1992) review focused on why the role of fathers has been relatively ignored in the study of child and adolescent psychopathology, and she found four major reasons for this. Firstly, parenting has been conceptualised by researchers as a “female area”. Secondly, many studies have been based on outdated assumptions such as fathers not having a role in child care and fathers not being important in child maladjustment. Thirdly, researchers have traditionally assumed that fathers are more difficult to recruit for their projects. Fourthly, Phares argues that research on parental psychiatric disorders has concentrated more on those disorders (such as depression) which have greater incidence in mothers than in fathers.

In the one major study that has investigated fathers with SMI (Nicholson et al., 1999), it was found that out of a sample of 806 psychiatric clinic outpatients with SMI, 21% of the men were fathers, while 46% of the women were mothers. Men who were not fathers were more likely to be diagnosed with a psychotic disorder and it was hypothesised that

this might be due to the early onset of psychotic illness preventing many men from taking on a fathering role. It was also found that the proportion of fathers who abused substances was significantly higher than that of non-fathers. The authors concluded that there is a need for qualitative research to investigate fathers with mental illness, to study their experiences, the range of factors affecting their goals, roles, and functioning as parents, and thereby help develop interventions.

Research Questions

The aim of the present study is therefore to address the need for a qualitative investigation into the experiences of fathers with psychosis. Some of the research questions which this study aimed to answer were:

1. What is it like to be a father with psychosis?
2. How do fathers with psychosis evaluate themselves in terms of fulfilling their idea of the parenting role?
3. Do fathers with psychosis have fears of passing on the illness to their children?
4. Do fathers with psychosis have fears of losing custody of their children?
5. Do fathers with psychosis experience feelings of blame, guilt or shame in association with fears of passing on the illness or losing custody?
6. How do the absences arising from hospitalisations for the illness affect caregiving arrangements, the relationship with the children and with the partner?

It was acknowledged that the experiences of fathers with psychosis encompass a vast quantity of phenomena, and this research could only aim to obtain a limited degree of

insight into the experiences of these individuals. The research acknowledged that different patients will have different perceptions about their condition. The principle aim was to have an accurate description of each participant and his unique perceptions. As exploratory qualitative research, this study did not aim to make statistical generalisations from this sample to a similar population. The strength of qualitative work is to explore ideas and generate hypotheses and only tentative generalizations could be made with regard to individuals in contexts outside the area from which the sample was taken. Any general findings would have to be the target of future research, possibly using quantitative methods. It was hoped that this research will generate interesting new ideas or hypotheses which can then be explored by other methods.

Chapter Two:

Method

Overview

The study involved the interview of ten male participants, all fathers with psychosis.

This chapter reports the recruitment, participant characteristics, data collection process, analysis and a summary of the researcher's perspective.

Ethical Approval

This study was reviewed and approved by Hounslow District Local Research Ethics Committee (Hounslow LREC). Later, when the study was expanded, the study was reviewed and approved by Barnet, Enfield and Haringey LREC. The letters of approval can be found in Appendix 1.

Recruitment

Inclusion criteria

The inclusion criteria for participants in this study were: (a) natural (biological) father of one's children; (b) a diagnosis of psychosis – schizophrenia, schizoaffective or other psychotic disorder; (c) White/Caucasian ethnicity; (d) aged 18 years or older; (e) stable with regard to their mental state, i.e. a patient on remission or maintenance treatment; (f) contact with one's children.

Rationale

It was essential to the aims of this study that the data be collected from fathers with a diagnosis of psychosis who have contact with their children. Fathers who have lost contact with their children may have their own experiences of fatherhood, but it was decided that this is a population more appropriate for a later study.

The sampling was limited to those of White/Caucasian ethnicity. This was necessary because difference and diversity between ethnic backgrounds may have a strong impact on attitudes to parenting and men's experience of fatherhood and their mental illness. Townsend (2002) discussed the cultural expectations of paternal responsibility and involvement in Botswana and the United States. Townsend argued that "*different cultures have different norms about which men, at which stages of their lives, should be doing what for children.*" (Townsend, 2002, p.274). The study of fatherhood must take into account how different ethnic and cultural groups hold different values and beliefs about father behaviour and child development. For example, the childcare a father provides in one culture might be seen as adequate within that culture, while another culture might have different norms, and view his childcare as inadequate (Gadsen, Fagan, Ray, and Davis, 2004). It was decided to limit the interviews to members of one ethnic background to reduce the effect of culture in confounding the interpretation of the results. The interview of fathers with psychosis from other ethnic backgrounds would be an aim of future research.

The sampling was limited to those who are biological fathers of their children. This is because differences between natural fathers and those who are step-fathers or foster

fathers may confound the analysis of the results from this study. One study compared children of biological fathers, stepfathers and partner's of their mother who were seen as father figures. This research found that children spend more time with their biological father (Hofferth, Pleck, Stueve, Bianchi, and Sayer, 2002). An aim of future research would be to repeat this study with men who are step-fathers or foster fathers.

Procedure

The setting

The participants were recruited from the patients of community mental health teams in West and North London. These teams are multi-disciplinary, consisting of community psychiatric nurses, social workers, psychiatrists, psychologists and occupational therapists. Each patient was on remission/maintenance treatment and had regular contact with a keyworker. The keyworkers co-ordinate the provision of care for each patient in their caseload. In addition the patients see a team psychiatrist at periodic intervals. Meetings between patients and their keyworker clinicians usually occur at the team bases, although they may also occur in the patients' own homes or elsewhere in the community.

The recruitment strategy

The researcher made presentations to community mental health teams, introducing the study and outlining the recruitment criteria. The Responsible Medical Officers (doctors) were provided with the full study protocol; other team members received staff information sheets (Appendix 2).

The *keyworker* clinicians of patients meeting the recruitment criteria were asked to identify themselves to the researcher. These clinicians were given the patient information sheet (Appendix 3), which introduced the study, and summarised the rationale and procedure, as well as possible pros and cons of participating.

The keyworkers were asked to introduce the research to potential participants in the course of their normal clinical duties by giving them a copy of the patient information sheet. If a patient expressed an interest in taking part, he was asked by his keyworker whether he would be prepared to be contacted by the researcher. Alternatively, each participant was given the option of contacting the researcher by telephone to arrange his participation in the study.

If a patient was interested in taking part in the study, the researcher arranged to meet him at a mutually suitable time and place, which was usually the community mental health team base. The researcher gave each participant an information sheet and made sure he understood the nature and purpose of the study, his right to withdraw from the study at any time, the mechanisms in place should he become distressed by the research, what would happen to the data collected and that the interview was to be audio-taped.

It was hoped that the participants would not find any of the interviews distressing. In the event that a participant became distressed or showed signs of becoming distressed during the interview, there was a plan in place to stop the interview and offer support. The participant would be given the choice of withdrawing from the study completely,

resuming the interviews after a break or continuing at a later date. If a participant required further support subsequent to distress arising from the interviews, there was a plan to recommend that he talk to his keyworker clinician and/or clinical psychologists involved in the research. In this instance, the keyworker would also be informed of the participant's distress. If a participant had any complaints about the study, he was informed that he may contact one of the clinical psychologists involved in the research on the telephone numbers provided on the patient information sheet.

Of the twenty-two men identified as meeting the recruitment criteria, six were reported not to be stable with regard to their mental state and/or they had very limited contact with their keyworker. It was therefore decided not to approach these patients about taking part in this project. Of the sixteen men who were approached by their keyworker about the research, ten agreed to participate and six refused to take part.

Participant characteristics

All ten of the participants described themselves as White-British. Their mean age was 51 (range: 34-67). Seven participants had been diagnosed with schizophrenia, two had a diagnosis of schizo-affective disorder and one had a diagnosis of delusional disorder. Four of the participants were unemployed, one was a househusband, three were retired and two were working. Seven participants described themselves as Christian, one as Pagan and two had no religious beliefs. All participants were stable with regard to their mental state. Only three of those interviewed had school qualifications, although five had learned a skilled trade such as roofing. Six of the participants had been imprisoned at some point in their lives. Six of the ten participants were living with their children at

the time of interview. Five participants were married, two were co-habiting with their partners, one was divorced and two were single. Four of the participants were grandfathers and one of these men was a great-grandfather. The participant characteristics are presented in Table 1. The data from the Brief Psychiatric Rating Scale is presented in Table 2. The data from the Childhood Trauma Questionnaire is presented in Table 3.

Table 1. Participant Characteristics

Age	Diagnosis	Details of Children M-male (age) F-female (age)	Frequency of contact with children	Marital status	Family living arrangements	Highest educational attainment	Occupation	Prison
F1 58	Schizophrenia	F(33) M(28)	Regular 2x week	Married	Lives with wife	Left school age 15 GCE qualifications	Retired skilled manual	No
F2 34	Schizophrenia	M(10)	With father	Single	Lives with own mother and child	Left school age 14 without qualifications	Unskilled manual	Yes
F3 37	Schizoaffective disorder	M(8)	With father	Married	Lives with wife and child	Left school age 16	Unemployed Skilled manual	Yes
F4 67	Schizophrenia	M(38) F(37).	1x year 2-3x week	Divorced	Lives alone	Left school age 15 without qualifications	Retired skilled manual	Yes
F5 54	Paranoid schizophrenia	M(19)	1-2x month	Single	Lives alone	Left school age 15 without qualifications	Unemployed	Yes

Table 1. Participant Characteristics (Continued)

Age	Diagnosis	Details of Children M-male (age) F-female (age)	Frequency of contact with children	Marital status	Family living arrangements	Highest educational attainment	Occupation	Prison
F6 64	Paranoid schizophrenia	M(44) M(42) F(35) M(34)	1x year 9-10x year 1x week 1x week	Married	Lives with wife	Left school age 15 without qualifications	Skilled manual	Yes
F7 66	Schizophrenia	F(37) M(36) F(35) M(33)	2-3x week With father 2x week 1x week	Married	Lives with wife and son's family	Left school 15.	Retired skilled manual	Yes
F8 34	Schizophrenia	M (1)	With father	Co-habit	Lives with partner and child	Left school age 17, Scottish Highers	Unemployed	No
F9 41	Delusional disorder	F(16) F(13) M(4)	None None With father	Co-habit	Lives with partner and child (son)	Left school age 16 without qualifications	Unemployed	No
F10 53	Schizoaffective Disorder	M (12) M(10)	With father	Married	Lives with partner and children	University Degree	Househusband	No

F4, F5, F6 – Grandfathers; F7 – Great-grandfather.

Table 2. Brief Psychiatric Rating Scale Scores

	F1	F2	F3	F4	F5	F6	F7	F8	F9	F10
1. Somatic Concern	1	2	3	4	5	5	5	1	4	1
2. Anxiety	5	3	4	1	4	4	2	4	4	5
3. Emotional Withdrawal	1	1	1	1	1	1	1	1	1	1
4. Conceptual Disorganization	1	1	1	1	3	1	1	1	1	1
5. Guilt Feelings	1	4	1	1	5	6	4	2	1	5
6. Tension	1	1	1	1	1	1	1	4	3	3
7. Mannerisms and Posturing	1	1	1	1	1	1	1	1	1	1
8. Grandiosity	1	1	1	1	1	1	1	1	1	1
9. Depressive Mood	4	1	1	5	1	1	3	1	6	4
10. Hostility	1	1	1	1	2	4	1	3	1	1
11. Suspiciousness	1	6	4	1	5	1	1	1	6	1
12. Hallucinatory Behaviour	1	1	5	1	3	1	1	1	1	1
13. Motor Retardation	1	1	1	1	2	1	1	1	1	1
14. Uncooperativeness	1	1	1	1	1	1	1	1	1	1
15. Unusual thought content	1	1	1	1	6	1	1	1	6	1
16. Blunted affect	1	1	1	1	3	1	1	1	1	1
17. Excitement	1	1	1	1	1	1	1	1	1	4
18. Disorientation	1	1	1	1	1	1	1	1	1	1

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe.

Table 3. Scores from the Childhood Trauma Questionnaire

	F1	F2	F3	F4	F5	F6	F7	F8	F9	F10
Emotional Abuse	7 None or Minimal	25 Severe to extreme	6 None or Minimal	13 Moderate to Severe	21 Severe to Extreme	15 Moderate to Severe	12 Low to Moderate	13 Moderate to Severe	23 Severe to Extreme	8 None or Minimal
Physical Abuse	5 None or Minimal	25 Severe to extreme	8 Low to Moderate	8 Low to Moderate	7 None or Minimal	19 Severe to Extreme	9 Low to Moderate	9 Low to Moderate	25 Severe to Extreme	8 Low to Moderate
Sexual Abuse	5 None or Minimal	5 None or Minimal	12 Moderate to Severe	5 None or Minimal	13 Moderate to Severe	18 Severe to Extreme	5 None or Minimal	5 None or Minimal	5 None or Minimal	7 Low to Moderate
Emotional Neglect	13 Low to Moderate	9 None or Minimal	17 Moderate to Severe	15 Moderate to Severe	12 Low to Moderate	18 Severe to Extreme	15 Moderate to Severe	15 Moderate to Severe	11 Low to Moderate	7 None or Minimal
Physical Neglect	7 None or Minimal	11 Moderate to Severe	12 Moderate to Severe	7 None or Minimal	11 Moderate to Severe	14 Severe to Extreme	14 Severe to Extreme	11 Moderate to Severe	5 None or Minimal	5 None or Minimal
Minimizat- ion/ Denial					1					

Measures

Interview

The interview consisted of four parts: a brief demographic questionnaire, a semi-structured interview on fatherhood, the Brief Psychiatric Rating Scale (BPRS) and lastly the Childhood Trauma Questionnaire (CTQ).

Fatherhood interview (Appendix 5)

Smith (1995) advocated the use of semi-structured interviews in qualitative analysis because they facilitate rapport between the interviewer and participant, they are flexible, they allow the participant to introduce new issues and they obtain richer data. There are drawbacks in that the semi-structured approach involves more work both during the interview and afterwards in the analysis stage, and the researcher has less control over the direction the interview takes.

A semi-structured interview was administered with each participant about the experience of fatherhood. The interview schedule was developed by reading the literature on fatherhood and the literature on parents with serious mental illness. This was followed by a discussion between colleagues experienced in Interpretative Phenomenological Analysis and scientific investigation in order to consider what might be of interest. With regard to the guidance of Smith (1995), the questions were written so as to avoid jargon and where possible, they were designed to be open and neutral. Some neutral questions were followed by more specific questions aimed at funnelling the interview to elicit accounts of experience which might not otherwise have been spontaneously reported.

In line with the guidelines of Smith (1995), the interview was flexible, took into account participants' understandings and included probing questions on interesting areas that arose. The questions in this interview were aimed at collecting data on each participant's subjective experience of being a father with psychosis, for example, how their psychosis has affected their ability to fulfil their role as a parent, what hopes and concerns they have about their own and their children's future. The interviews were audio-taped to facilitate their analysis.

The fatherhood interview was piloted with the first participant of this study. After this pilot interview, the researcher reviewed the content of the questionnaire. It was found that the participant had no difficulty in understanding the questions, although the wording of certain questions had to be adapted. It was decided to make no changes to the interview schedule but to rephrase and repeat a question if a participant had difficulty understanding the wording.

BPRS

The Brief Psychiatric Rating Scale (BPRS) (Overall and Gorham, 1988) was administered to all participants. This is a widely used clinician-rated instrument designed to assess severity of psychopathology, and was originally designed to measure symptom change in patients with psychotic illness. The BPRS was not used to make conclusions for the whole sample. Like the CTQ, the BPRS was used to situate the sample, by providing more information on the life circumstances of the participants.

The reliability and validity of the BPRS have been shown by numerous studies to be generally high (Hedlund and Vieweg, 1980). Hedlund and Vieweg reported that they had found ten reliability studies of the BPRS which reported reliability co-efficients of .80 or greater for the BPRS total pathology score. Regarding the construct validity of the BPRS, Hedlund and Vieweg reported on 25 BPRS factor analyses, and they concluded that there was a high level of consistency amongst the factor analytic data. Regarding the concurrent validity of the BPRS, Hedlund and Vieweg reported that the BPRS has been administered alongside many other measures such as the Clinical Global Impressions Scale and the Hamilton Rating Scale for Depression. The reviewers stated that the BPRS has consistently reflected changes in the mental health of patients that are corroborated and supported by these other clinical rating scales (Hedlund and Vieweg, 1980). It usually takes 25-30 minutes to complete the BPRS, although it was usually completed in five minutes in this study because the participant's mental state during the fatherhood interview was used to answer most of the BPRS items. The BPRS interview was audio-taped to facilitate analysis.

CTQ

The Childhood Trauma Questionnaire (CTQ) (Bernstein and Fink, 1998) was administered to all participants. It is a widely used 28-item self-report inventory which provides brief screening for childhood histories of abuse and neglect. In this study, the CTQ was used to situate the sample by providing more information on the life circumstances of the participants. The CTQ was not used to make conclusions for the whole sample. It is a useful tool, allowing more difficult questions about childhood to be asked succinctly.

The CTQ takes around five minutes to complete. Individuals are asked to respond to statements about childhood occurrences of emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect. Responses are made on 5-point Likert-type scales ranging from *Never True* to *Very Often True*. The CTQ incorporates a 3-item Minimization/Denial Scale to help identify individuals who have a tendency to give socially desirable responses or false-negative reports.

The internal consistency reliability of the CTQ was studied across seven samples of clinical and non-clinical individuals (total N = 2201). Internal consistency coefficients for the CTQ scales were computed for all validation samples using Cronbach's alpha, and ranged from satisfactory (median = .66) to excellent (median = .92). The test-retest reliability of the CTQ was studied with a sample of 40 adult substance abusers.

Readministration was after a test interval of around four months (mean = 3.6 months, SD = 1.0). Intraclass correlations between the first and second tests were high (overall $r = .86$). Regarding the content validity of the CTQ, items were written to reflect the types of emotional, physical and sexual abuse and emotional and physical neglect reported in the childhood maltreatment literature. Factor analyses were performed, indicating that the five constructs measured by the items have coherence and viability across clinical and non-clinical populations (Bernstein and Fink, 1998).

Demographic questions

The researcher administered a brief demographic questionnaire aimed at collecting relevant information to the study, including how often participants have contact with their children and their family living arrangements.

Analysis

Interpretative Phenomenological Analysis

The interviews were analysed using Interpretative Phenomenological Analysis (IPA). It is a method of qualitative analysis which involves the researcher's interpretation of the research participant's experience of phenomena. In other words, IPA views the researcher as a person making an attempt to understand another individual's psychological world. One of the central ideas of IPA is that the content of what people say is a manifestation of their own psychological reality. The IPA method acknowledges that direct access into someone's internal world is impossible. Nevertheless listening to what a person says provides a degree of insight into phenomena as experienced by that person. Therefore the approach can be described as *phenomenological* (Smith, 1995; Smith, Jarman, and Osborn, 1999).

IPA is “...concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objectified statement of the object or event itself”(Smith et al. , 1999, p. 218).

The IPA researcher aims to make sense of a person's psychological reality and obtain some measure of an "insider's perspective". However, this is not possible without the use of the researcher's own conceptions arising from his or her own psychological reality. The IPA researcher therefore makes an *interpretation* of what the participant has experienced. Smith (1995) encourages creativity in the work, providing methodological guidelines which can be adjusted to suit each researcher's own interpretative process. Such analytical flexibility is essential when the method relies on the researcher's own conceptions of the world to make a series of interpretations on the phenomena under study.

IPA attempts to understand the "nature or essence of phenomena", (Willig, 2001, p. 69), developing an understanding of the participant's perspective. While Grounded Theory tries to describe the processes which "account for phenomena", and may even try to develop theories of causation, IPA attempts to adhere to meanings the participant is giving because it is concerned with the immediate psychological reality of a participant, rather than attempting to describe underlying processes. Grounded theory sometimes attempts more causal explanations, as might a sociologist in explaining phenomena. IPA differs from Discourse Analysis in that it is concerned with the cognitions underlying the verbal communications of the individual, rather than the tasks being performed by the discourse itself (Smith, 1996; Smith et al., 1999; Willig, 2001).

IPA was chosen because it is arguably the most useful qualitative method for investigating the experience of individuals. Unlike Grounded Theory, which was developed to explain underlying social processes which "account for phenomena"

(Willig, 2001), the aim of IPA is to attempt to explore in detail how participants make sense of their personal and social world (Smith and Osborn, 2003). Unlike Grounded Theory, which merges the processes of data collection and analysis, the IPA methodology makes it possible to interview participants in a single interview. This feature of IPA was particularly important due to the nature of the population under study, who probably would have found it difficult to participate in repeated interviews. IPA was also determined to be more appropriate than Discourse Analysis for the present study. This is because the aim of this study was not to investigate the tasks being performed by the discourse of the participants. Rather, the aim was to investigate the experience of the participants (Willig, 2001).

Analysis with IPA

The analysis was based on the guidelines of Smith et al. (1999) and Willig (2001). The first stage of the analysis was to read the transcript of the first interview several times, noting initial thoughts and observations, interesting or significant discourse and preliminary interpretations on the left margin of each page. Then having gone through the transcript and made these notes, the next step was to note emerging theme titles on the right margin. These are key words which summarise the tentative themes identified thus far.

The second stage was to list these emerging theme titles on a separate sheet and to look for connections between them. Themes which were construed to be related, for example, those that shared meanings, were then clustered together. Each new cluster of themes was classified with appropriate labels. During this process, the researcher returned

several times to the original transcript in a reiterative process, checking that these new superordinate themes incorporated connections which were reflected in the participant's account. This was to act against the researcher's own bias in the interpretative process.

The third stage involved making an ordered table of the themes from the second stage, and illustrating these themes with quotes from the transcript. Then certain themes were discarded. These were themes which were not well supported by evidence in the transcript or did not appear to adequately relate to the participant's experience of the phenomenon being studied.

In the fourth stage, the process outlined above was repeated with the other interview transcripts. The master lists of each interview were then read together and consolidated into a list of master themes for the group of ten participants. As at the other stages of the analysis, the researcher returned to the transcripts to check that emerging master themes reflected the participants' communication of their experience. By comparing and contrasting the themes across the range of participants, the IPA process aims to evaluate the robustness of the findings from any one interview and compile a final master list of themes which have emerged from the data.

The fifth stage was to communicate the final list of master themes in the form of an account illustrated by quotes from the transcripts which capture crucial aspects of the participants' experience. This is presented in the results section.

Credibility checks

Elliott, Fischer, and Rennie (1999) have argued that qualitative research studies require checks on the credibility of their results so that the reader will have information with which to evaluate the study. “Good” qualitative research should involve researchers disclosing their own values and assumptions, participants should be described in detail, interpretations should be “grounded” in examples from the original data, other researchers should provide credibility checks, analyses should be presented coherently, and the aims of the study should be explicit.

With regard to the present study, steps were undertaken to evaluate the credibility of the results. Credibility checks on the analysis were conducted, in which a second researcher, an expert in IPA, conducted a data audit and an analysis audit, in which codings were tested by returning to the original data. There was an examination of how specific evidence was described in wider frames, and some categories were discussed and changed in agreement between the two researchers (Elliott et al., 1999; Willig, 2001). Following a detailed discussion between the two researchers, a final master thematic framework was then created.

The researcher’s perspective

Good practice in qualitative research involves reflexivity. This means acknowledging the effect of the researcher’s attitudes, values and experience on the conduct and results of the study. It is recognised that objective, value free research is not possible and there are inevitable effects arising from the subjectivity of the researcher. Therefore it is

useful to be informed of the researcher's perspective so that one can have a degree of awareness about his or her contribution to the results of the study (Smith, 1996; Pidgeon and Henwood, 1997).

I am a male of mixed ethnicity, being half-white and half-Chinese, but I have grown up in Western society. Prior to my clinical psychology training, I worked in a community team providing an assertive outreach service to individuals with severe and enduring mental health problems, principally psychotic illnesses. I also worked as a researcher on an evaluation project of a user employment programme. This post brought me into contact with a wide range of patients in rehabilitation, acute and forensic settings. Through these experiences, I had some prior awareness of the stresses people with psychosis endure, both as a direct consequence of the psychotic illness itself and indirectly through problems with relationships, finances, housing, employment, discrimination and experience of stigma. It is possible this prior awareness of the life experiences of people with psychosis influenced how I approached this research.

I am not a father, although I hope to become one in the future. There consequently may have been some personal bias in the probe questions of the semi-structured fatherhood interview, due to my personal interest in the nature of fatherhood.

As a trainee clinical psychologist, I have a clinician's perspective as well as a researcher's perspective. I was monitoring the participant's mental state to be aware of possible distress and to inform the BPRS assessment. This dual role may have influenced the interview.

Chapter Three:

Results

The final list of master themes is presented in this section, illustrated by quotes from the transcripts which capture the essence of the participants' experience. The interpretative phenomenological analysis yielded fifteen themes, which are organised into six domains. Many of the themes are themselves divided into sub-themes. The full set of domain, theme and sub-theme titles is presented in Table 4.

Each of the quotations is followed by notation to indicate the participant who made the quote, for example, (F8) is the eighth father to be interviewed for the study. Square brackets, (containing a word denoting a particular person) have been used to replace an instance in which a person was referred to by name. This has been done to maintain the anonymity of the participants. For example, *[daughter]* was used to replace a mention of a participant's daughter by name. Certain quotations also use curved brackets containing a word denoting a particular person. The word within these brackets has been added by the researcher in order to clarify who the participant is talking about.

It is noted that due to the nature of the interview schedule, although a great deal of the results are emergent themes which are based upon the participants' spontaneously reported experiences, some of the results are themes based upon responses to direct questions. This means that although all of the themes reflect aspects of the participants' experience, the direct questions may have prompted participants to report experiences

which were less salient and therefore may not have reported if they had not been prompted to do so.

The direct questions were preceded by more neutral questions, and were aimed at eliciting reports of experience which might not otherwise have been elicited. Smith (2003) discusses how asking questions in a funnelling sequence such as this allows the respondents to give their own views before funnelling them into more specific questions of particular concern to the investigator.

The first domain, *The experience of psychosis*, was made up of three themes: *Experience of psychosis*, *Psychosis originated in childhood* and *Other relevant experience*.

The second domain, *Impact of psychosis on experience of being with children*, incorporates experiences of how psychosis has affected the father-child relationship. This domain was divided into the following themes: *Psychosis affects ability to do the job of a parent* and *Indirect impact of psychosis*.

The third domain was: *Impact on partner*. It consists of one theme: *Psychosis has undermined my relationship with my partner*.

The fourth domain was: Hopes and fears of fatherhood. This was divided into the following themes: *Mixed feelings about own father*, *Negative experience of mother*, *Ideas of fatherhood before becoming a father*, *Hopes for a positive legacy* and *Concerns about a negative legacy*.

The fifth domain was: *Impact of parenting on the fathers themselves*. This was divided into: *Positives of parenting* and *Negatives of parenting*.

The sixth domain was: *I need support to be a father with psychosis*. The most important source of support appeared to be the partners of the participants. It was divided into two themes: *Support from partner important in coping with child care and coping with the illness* and *What helps? What would help?*

Table 4. Summary of Domains, Themes and Sub-themes

Domain 1: The experience of psychosis

Theme 1 - Experience of psychosis

Psychosis is unpleasant to me
Negative effect on employment and housing
Positive experience of psychosis

Theme 2 - Psychosis originated in childhood

Theme 3 - Other relevant experience

Recovery experience
Employment is an important experience
Worry about money and housing

Domain 2: Impact of psychosis on experience of being with children

Theme 4 – Psychosis affects ability to do the job of a parent

Theme 5 – Indirect Impact of Psychosis

Medication
Hospital

Domain 3: Impact on partner

Theme 6 - Psychosis has undermined my relationship with my partner

Domain 4: Hopes and fears of fatherhood.

Theme 7 - Mixed feelings about own father

Theme 8 - Negative experience of mother

Theme 9 - Ideas of fatherhood before becoming a father

Not to repeat history / to do it differently
To care and be involved
To be like my father
I didn't think about it

Theme 10 - Hopes for a positive legacy

Hope for children's relationships
Hope for children's education and employment

Theme 11 - Concerns about a negative legacy

Passing on the illness
Don't let history repeat itself

Table 4. (Continued)

Domain 5: Impact of parenting on the fathers themselves

Theme 12 - Positives of parenting

Pride in the father role

A sense of purpose

Pleasure in the creation and development of life

Motivation to change for the better

Bonding

Support and understanding from children

Reflection about evaluating self unfairly as a father

Theme 13 - Negatives of parenting

Parenting brings added worries and stress which can sometimes make the psychosis worse

I've failed as a father

Domain 6: I need support to be a father with psychosis

Theme 14 - Support from partner important in coping with child care and coping with the illness

Partner supports me

Partner supports the family

Mutual support

Theme 15 - What helps? What would help?

Family

Professional services - Someone to talk to

Professional services – Understanding of needs

Professional services – Support when I'm not well

Professional services – Practical support

Domain 1: The experience of psychosis

The first domain, *The experience of psychosis* consisted of three themes: *Experience of psychosis*, *Psychosis originated in childhood* and *Other relevant experience*. The participants described a range of unpleasant experiences associated with having psychosis. The onset of psychotic illness was linked by several participants to their childhood, which included physical abuse, having a parent who was mentally unwell, or having siblings with chronic physical illness. Psychosis incorporated feelings of confusion, a sense of disconnection from oneself and others, stigma, emptiness, loss of

control, loss of confidence. The distress may lead one to withdraw from activity in order to cope. It can also have a negative effect on one's quality of life. Psychosis was also associated with experiences of harm to oneself and self-destruction.

Being in employment was mentioned as an important role, one which can bring with it a sense of pride, and it can be therapeutic because of the activity involved in working. However, psychosis was reported to have a negative effect on one's employment and housing. Therefore the anxiety over finances and housing reported by many of the participants may be linked to previous negative experience. The experience of recovering from psychosis had led to a body of knowledge about how to cope when mentally unwell, as well as an increased confidence in facing the psychosis.

Theme 1 - Experience of psychosis

This theme incorporates the life experiences that the participants associated with having psychosis. The three sub-themes of this theme are: *Psychosis is unpleasant to me*, *Negative effect on employment and housing* and *Positive experience of psychosis*.

Psychosis is unpleasant to me

The participants described various unpleasant experiences which appeared to be directly associated with psychosis. Psychosis was associated with a sense of confusion:

"...sometimes you don't even know when you're here or there..." (F3). It was also reported as being accompanied by a sense of disconnection from oneself and from others. One father described being out of touch with his own emotions: *"...I've felt as though I've been out of touch with my emotions and not really knowing what I want for*

myself, and life in general" (F10). Another father felt a disconnection from society, despite his efforts to overcome this:

I always felt that I wanted to be a part of society and I tried to be a part of it. But I can't work with people, you know. But I can't relate to people at all. I can't get on with them.
(F5)

One possible factor in this feeling of disconnection from society is the stigma the participants experience as people with mental health problems. One father said: "*We tend to get treated like children, mental patients, you know. Patronised, you know... we get talked down to...*" (F5).

Psychosis was also associated with a feeling of emptiness in one's life: "*I felt like I was going through blankness, you know. Like through a void, it sort of felt like. A very empty place that was*" (F5). For another father, there was a sense that psychosis can take control and cause a change in behaviour: "*...the schizophrenia turned its face and created violence within me...*" (F1).

Psychosis was seen as a source of great distress: "*Well when I did have my breakdown with schizophrenia it's total paranoia. You're hallucinating, you're doing God knows what. It's an absolute nightmare*" (F1). The distress that is experienced may lead to a need to withdraw from activity in order to cope: "*...I've tended to close down my life to the minimum necessary... beyond that I don't do much at all, in retreating to bed and*

sleeping" (F10). Relapses can entail repeated losses of confidence, from which one has to work hard to recover:

It's knocked my self-confidence a lot. Each time I'm ill, it puts me back and I have to work forward to try and get back to an equanimity, a feeling that I know where I am and what I'm doing. (F10)

Struggling with psychosis can negatively affect satisfaction with one's quality of life:

"...with my illness... life's not enjoyable...for quite a lot of the time, cause I'm struggling with my sort of mental health problems" (F8). One participant described how attempting to deal with his psychotic paranoia was a contributing factor in the development of his alcoholism:

...I don't like going out all that much, you know, where I've still a bit paranoia. When I used to drink, I used to go in there and build up a few beers, and thinking that, you know, you're paranoia, and then them few beers... so I weren't paranoia no more. (F6)

For some of the participants, psychosis was associated with harm to oneself. Two of the participants reported past suicide attempts. For example, one father said that he had

taken an overdose of medication: *"...I took an overdose... I was hoping not to come out of it... at that time I didn't care..."* (F9). This participant also described how he had neglected to care for himself as a result of the psychosis: *"So I barricaded myself in. I didn't go out. And I wasn't eating neither because I was giving my money away. I didn't care about things"* (F9). With one participant, there was a sense that psychosis is an

experience incorporating feelings of self-destruction: “...*fighting myself in a sense*” (F10).

Negative effect on employment and housing

Another set of themes which were part of the negative experience of psychosis involved the issues of unemployment and housing. Unemployment in particular was a common theme amongst the participants in this study. One father said that his psychosis had prevented him from working, which meant that he could not afford the mortgage payments and his home had then repossessed:

...just losing a house, that was traumatic enough... that was a direct effect of my illness and the times where I couldn't work. So we got behind with everything and one thing led to another and that was it...we lost everything. (F1)

Positive experience of psychosis

A few of the fathers identified ways in which psychosis had made a positive contribution to their parenting experience. One father mentioned that his wife had developed in confidence and ability in the process of supporting their family, because the psychosis had rendered him unable to do so himself:

...in some ways it's been good because... that gave her an opportunity to establish her own independence and her own abilities... she gained in self-confidence through having to cope... where I was competent there'd been no need for her to gain her own competence. (F10)

Theme 2 - Psychosis originated in childhood

Several participants felt that their negative childhood experiences had contributed to the development of their psychosis. They mentioned a range of such experiences, including physical abuse, living with a mentally ill parent, and having siblings with chronic physical illness. One father attributed his psychosis to the stress of living with his mother's mental health problems:

I was the only one left at home... I took all of it, you know, what she was going through at times. I was taking it all in...that's what brought my illness on I think, right when I was a boy... seeing my mother like that... (F4).

Another father attributed his psychosis in part to the physical abuse he received from his step-father: “...being beaten by him (step-father) and my work colleagues... what turned me into a paranoid illness, you can call me schizophrenia” (F2).

One participant felt that the emotional disconnection he associates with psychosis originated during his childhood:

I didn't feel part of it at all, part of every other little child. I didn't feel part of the fun and games... I felt there was something that had invaded me, you know, that stopped me sort of getting to know other little children... (F5)

Theme 3 - Other relevant experience

There are three relevant sub-themes to this domain, not contained in the main themes.

These are: *Recovery experience*, *Employment*, and *Worries about money and housing*.

Recovery experience

Several of the participants mentioned how they valued their experience of recovering from psychosis. They had accumulated skills and confidence in dealing with their illness in the course of their numerous relapses and recovery periods:

No it won't get the better of me. I've learned to think in different ways. I've had to. I've had to rip my mind to pieces and put it back together so many times...your mind adapts, your thinking pattern adapts... (F1)

They had also developed increased insight into their mental illness:

...I've found over the last 3 or 4 episodes, that I've actually gained some very significant insights into my illness. I've understood much better where it's coming from. Where it's coming from inside me. (F10)

Employment is an important experience

The majority of the fathers mentioned the importance of the work role in their accounts.

A few of the fathers described a sense of pride in the working role. For example, one father said: *"I've always worked if I could, you know. Even when I've been on the sick I've been getting a little job here and there"* (F7). The activity provided by employment

was described as therapeutic by another father: “...*I try to help someone out with some work...that gets me out of any boring states of mind... it brings me back to normal*” (F4).

Worry about money and housing

Anxiety over finances and housing was a common theme amongst the participants. For one father, this stress had precipitated the first episode of his psychosis:

...my wife fell pregnant with our first one. But unfortunately it triggered off a psychosis. That's what originally led to the first breakdown I had. The pressure and the responsibility of having only one wage packet...the mortgage was heavy...the pressure was incredible... (F1)

A few of the other fathers had experienced living in inappropriate accommodation, for example, one participant said he had lived in a council flat which was too small in which to bring up a child: “*Well it was a one room, we just had a sort of bedsit, it was one room where myself and my partner and the baby were sleeping, and a kitchen and a bathroom, so that was quite stressful*” (F8).

Domain 2: Impact of psychosis on experience of being with children

The second domain, *Impact of psychosis on experience of being with children*, incorporates experiences of how psychosis has affected the father-child relationship. This domain was divided into the following themes: *Psychosis affects ability to do the*

job of a parent and Indirect impact of psychosis. The most relevant of the findings contained within this domain is that psychosis was seen as having a negative impact on the ability to fulfil the father role, and that this appeared to be via direct and indirect paths. For example, psychosis can have a direct effect by making participants feel emotionally disengaged from their children; psychosis can have an indirect effect by means of relapses necessitating hospitalisations and therefore separations from one's children. It appears that the major impact of psychosis on fatherhood is that it undermines the relationship between fathers and their children.

Theme 4 – Psychosis affects ability to do the job of a parent

Psychosis affected the ability of many of the participants to do the job of a parent. One important effect of the illness appears to be the way in which it undermines the relationship between the fathers and their children. A few of the fathers reported that psychosis had made them feel emotionally disengaged from their children. For example, one father said: “...*something inconceivable took over me body and I can't sort of like be a father to him... I don't feel fatherly to him at all... I feel isolated from him*” (F5).

With another participant this feeling of disengagement appeared to originate in his paranoid delusions:

Well because you alienated them from your mind... they're my children but they're not my children... it's a horrible feeling. You know, it's to believe they weren't my children...I was... a bit offish with the kids, because I'm thinking they know what I'm

going to say, and things like that... knowing that they can read me brain. Thinking that they can read me brain. (F6)

One father speculated that his poor relationship with his son was attributable to his psychosis, which had rendered him emotionally disengaged from his son: *"... he's very angry towards me... there's no reason particularly, unless of course that numbness of being a father, you know, that he's angry with me..." (F5).*

A few of the fathers appeared to be concerned about how their children perceived them when they were mentally unwell. For example, one father said: *"If I'm that unwell, I'm sectioned... so I don't want him to see me, like, that bad"* (F2).

Psychosis was described as having a negative impact on one's attention and memory, which in turn affected one's ability to fulfill the father role. One participant talked of his regret that he had not been able to give his son sufficient attention during his childhood, because psychosis had had a negative effect on his concentration: *"...concentration... it's very hard sometimes to maintain...I never gave my boy enough. I regret giving him not enough attention when he was younger"* (F1). Another participant described how he had had problems with his memory, which he attributed to his psychosis. He had forgotten important parental responsibilities, such as picking up his child from school. This led to a feeling of shame at having failed as a father:

...when I have those slips of memory, which are part of my illness, something major will get lost... and when it relates to the kids, that makes it hard to be a dad. I feel ashamed of having fallen short of my standards... in what I should be doing. (F10)

The relapse of psychosis was an especially difficult time for the participants. For one father, relapse presented him and his wife with the prospect of having to place their child under the care of social services. There was a concern that his wife, who also had mental health problems, would be unable to cope with the childcare on her own: *"I was ill for 3 months... there was talk of putting him into care, because my wife couldn't cope with him for 3 months..."* (F3). Another participant appeared to experience the unpredictability of relapse as a chronic source of stress, due to the associated separation from his family: *"You can never tell when you have to go to hospital and lose that contact"* (F2).

Theme 5 – Indirect Impact of Psychosis

The need for medication and the hospitalisations accompanying relapse appeared to be the two major ways in which psychosis indirectly affects the lives of the participants and also their ability to parent.

Medication

There was a sense that the participants experienced the medication for their psychosis as having both beneficial and detrimental effects. The side effects of this medication were reported to affect one's energy level: *"...the tablets make me very tired. And if I don't*

get enough sleep I get niggly” (F9). Medication also affects one’s concentration: “I find it affects my concentration, the injection” (F1).

Two of the participants described how medication had affected their ability to father their children. For one participant, medication felt like a straitjacket, constraining his ability to display emotions to his son: “...*Largactil didn’t permit me to have conversations with him or be a father to him... it’s like a straitjacket, a mental straitjacket you see, emotional straitjacket. So difficult to show feelings with that stuff inside ya*” (F5). The other participant said that he had lost consciousness while caring for his young son and attributed this to his medication: “...*one time, my wife left the house. I had my son there... and I blacked out for 3 hours... to do with the medication...*” (F3).

Medication’s sedative properties had an adverse effect on one father’s ability to have regular employment:

I’m on Clopixon. I have it on a Thursday and come that weekend, the following weekend, I spend a lot of time asleep, it does really wire me up. So as far as actually holding a job down, no chance... (F1)

One participant said that both he and his wife took anti-psychotic medication. He was concerned that the medication was associated with a risk of a child developing Down’s Syndrome. He had therefore decided not to risk having any more children: “...*I wouldn’t risk having another child anyway, because I’m on Olanzapine which can, and my wife’s*

on Olanzapine as well, which can give off (Down's syndrome) children. I've been told that by a GP" (F3).

Hospital

Hospitalisation due to an acute episode of psychosis was generally a negative experience for the participants. The separations from the family appeared to be an unpleasant aspect of hospitalisation. For one father, there was a sense that psychosis had removed him from important family events: "*...I haven't been there for them sometimes because I've been in hospital...I was in there when my wife celebrated her fortieth birthday... the illness actually took me away from events that I should have been there*" (F1).

Contact with family members while in hospital was hampered by a concern that visiting a mental hospital might distress one's children: "*I'm a little cautious about having them in to see me, the ward, cause... some people are quite disturbed and it can be quite upsetting for them*" (F10). One father described the wards in a mental hospital as dangerous and inappropriate for his son to visit. For this reason, he decided not to have physical contact with his son while he was in hospital:

I've never let him visit me, I can't let him see what the kind of people that I'm living with... especially with the amount of people on the ward that have got really bad illnesses, and my son could be in... anything happens on them wards, fighting, anything... (F2)

Although this was a difficult separation, this father attempted to make up for the lack of physical contact by writing letters and telephoning:

I miss out, and my son misses out on my contact... not seeing me son when I'm on Section 3, maybe 4 months in hospital. And that really hurts, but I do keep phone contact and writing letters twice a week. (F2)

Perhaps as a result of the inappropriateness of a mental health ward for family visits, another father reported that his family would not come into the ward, deciding instead to meet him outside, in the hospital car park: *"They never came in, they was outside in the car park... my ex-wife never wanted to come into a mental hospital..." (F4).*

Hospitalisation was a time of reflection for one father: *"...the whole experience of going into hospital and having to re-evaluate a lot of the pain with your life..." (F8).* However, another father felt that his inactivity while in hospital did not prepare him for the return home:

...I'm not going to come out of a situation in hospital where I've been completely catered for, absolutely nothing to do... months adjusting to doing absolutely nothing... then come back into an ordinary situation at home and sort of leap back into doing everything. (F10)

Domain 3: Impact on partner

The third domain was: *Impact on partner*, which consisted of one theme: *Psychosis has undermined my relationship with my partner*. A few of the participants described how their psychotic illness has had a negative effect on their relationship with their partners.

Theme 6 - Psychosis has undermined my relationship with my partner

For a few of the participants, psychosis had undermined the relationship with their partner and one participant attributed the breakdown of his marriage to his psychosis.

One father had had paranoid delusions about his wife: "*I used to think she was part of the plot...me wife I thought was part of a conspiracy and all*" (F6). Another feared that his psychosis placed too much stress on his wife, and he worried that she would leave him because of this:

I feel that the current situation is unsustainable. I think that the pressure I'm putting on [wife]... is something nobody should be expected to take for any length of time. And the ultimate is divorce really... if it gets to the point where it isn't worth her living with me because it's more trouble than it's worth. That would be horrifying... the collapse of my world... (F10)

Domain 4: Hopes and fears of fatherhood

The fourth domain was: *Hopes and fears of fatherhood*. This was divided into the following themes: *Mixed feelings about own father*, *Negative experience of mother*, *Ideas of fatherhood before becoming a father*, *Hopes for a positive legacy* and *Concerns*

about a negative legacy. The majority of the participants did not appear to have experienced nurturing, predictable, authoritative parenting. Before becoming parents, only a few of the participants had decided to model themselves on their own fathers, the majority deciding to be different from their fathers in raising their own children. Now that they had become fathers, their hopes for their children's future appeared to be concerned mainly with their success in relationships, education and employment. Their major concern about their children's future was that they would inherit the psychosis and have to suffer the same negative experiences that they had themselves.

Theme 7 - Mixed feelings about own father

The majority of the participants had mixed feelings about their own fathers. On the one hand, their fathers were described as trying their best under difficult circumstances, working hard to support the family but still managing to spend time with the participants when they weren't at work. However, on the other hand, these same participants also felt a lack of attention from their fathers and a sense of emotional disengagement from them. For example, one participant described how his father was helpful to him: "*He always tried to help me where he could*" (F4). However, he also said that he had had a poor relationship with him: "*He were terrible. He used to swear at me terribly... he didn't give me much co-operation*" (F4).

One participant appeared to associate these mixed feelings with a change in the relationship with his father over the course of his childhood. In his early childhood, he felt that his father had been kind and gentle: "*Very kind. Very gentle...we'd see plenty of him at the weekends...I didn't feel deprived of his company*" (F10). However, later in his

childhood, the relationship between him and his father had deteriorated: *"I was a bit distant from him...by the time I was 10 I had sort of lost touch with where my father was. What he was thinking, what he was doing"* (F10).

Another participant described how his father had physically abused him and yet he valued his father's financial support of the family. He talked of the abuse: *"Bastard... knocked me out one night 3 times. Woke me up, throw cold water over, knocked me out again... I don't forgive him for that"* (F6). However, he also talked of his father's hard work: *"I gotta give him his due, he always worked but he liked his pint every night"* (F6).

For some of the participants, the mixed feelings were associated with their father's heavy drinking habits: *"He did have bouts of when he was having his drinking a lot... and he was quite a difficult person to be around"* (F8). One participant had re-evaluated what he thought of his father when contemplating his own fathering difficulties: *"...in the end I didn't trust my father... but if I have a child, what I think, would my child trust me? You know, well what would I do with my child?"* (F3).

Some of the participants described only negative experiences of their own fathers, including feelings of emotional disconnection and being neglected. One participant had had no contact with his biological father since he was a baby. His step-father had been an alcoholic and physically abusive: *"He started drinking lots of alcohol, spent all his money on gambling. He'd come home, he'd beat me, me brother and sister up"* (F2).

Theme 8 - Negative experience of mother

Some of the participants reported childhoods with negative experiences involving their mothers. A few of the participants reported that their mothers had had mental health problems, which had been a negative aspect of their childhood experiences, mainly due to the frequent hospitalisations and associated family separations: "*She went mental...and me mum was put in hospital and we never used to see her from one year to another*" (F7). Another participant felt that he had been held responsible for his mother's post-natal mental illness: "*I think she had a lot of depression when I was born, I think, and I got the blame for it I think*" (F5).

One of the participants said that his mother had been physically abusive, both to his father and to himself. He recalled the sadistic nature of his mother's abuse: "*...I used to get hit with hard objects from my mother... I think she got pleasure out of doing it*" (F9).

Theme 9 - Ideas of fatherhood before becoming a father

The participants recalled what they had thought of fatherhood before their first child was born. The most prominent theme was: *Not to repeat history / to do it differently*. Only a few of the participants had decided to use their own fathers as role-models for fatherhood.

Not to repeat history / to do it differently

Several of the fathers said they had decided to raise their own children in a different manner from their own upbringing. There was a sense that they perceived their own

fathers as “anti-role-models” and there was a determination not to allow history to repeat itself:

I had an idea, from a very early age, from the age of 16, I thought if I ever have a son, I'm going to treat him totally different to the way my (step) dad treats me. He's never going to be punched, kicked, beaten, sworn at, nothing. He's going to have it nice and easy and a better chance than I got started with in life... like a paternal instinct. (F2)

To care and be involved

Before they had children, several participants had contemplated what sort of fathers they wanted to be. The most frequent of their thoughts on fatherhood was that fathers ought to be caring and involved with their children: *“To be fair to them and try and help them as best as I could” (F7).*

To be like my father

A few of the participants had decided to use their own fathers as role-models in their parenting: *“...I believe you should take after your real dad... now I'm flowing it into me son...” (F2).*

I didn't think about it

A few of the participants said they had not thought in great detail about what sort of fathers they wanted to be in the time before they had children: *“...I didn't even think about becoming a dad. Just happened by accident. Cause it just happened. I didn't plan it or nothing” (F9).*

Theme 10 - Hopes for a positive legacy

The participants talked of their hopes for their children's success in relationships, education and employment.

Hope for children's relationships

A few of the participants expressed hopes that their children would find partners: *"Well I'd like to see him married one day... I just hope that he finds someone who'll think a lot of him..."* (F4). One father said he hoped his children would one day have families of their own: *"...ultimately I hope they'll both find fulfilment in having a family. And having their own experience of what it is to be parents"* (F10).

Hope for children's education and employment

Several participants had hopes that their children would have successful education and employment opportunities: *"...the main thing, I hope he gets a few years behind him working, get his education all sorted out..."* (F3). For a few of the participants, these hopes were associated with the theme about the positive benefits of keeping active: *"I just reckon [daughter] gonna get up and go to work... cause like, sitting at home, it's no good really. It only gets you down... so it's better off getting up and going out"* (F9).

Theme 11 - Concerns about a negative legacy

The major concern of the participants was that they had passed on psychosis to their children. The participants appeared to place this concern above any other.

Passing on the illness

Concern about passing on psychosis to one's children was a widespread theme for the participants. There was an anticipatory anxiety associated with the education they had received about genetic factors in the development of psychosis. Psychosis appeared to be experienced as a "time-bomb" which might or might not be triggered. Many participants were waiting to see whether or not their children would develop psychosis, fearing that history would repeat itself, and that their children would have to suffer the same negative experiences that they themselves had:

That they'll be able to get through life without having to suffer the sort of illness I've had... I know there's an increased likelihood that they will have a psychotic illness because I have one. I hope that the dice will come up their way and they won't have it.
(F10)

One father described how the fear of passing on his psychosis had been his first thought when he learned that his partner was pregnant: "...the first thing that come into my head, is cause like, I was told by my psychiatrist that my illness is hereditary, you know from my father. He had schizophrenia, my real father" (F2). He talked of his anxiety over history repeating itself: "It was like, just don't get the schizophrenia like I got, cause you know, I wouldn't like to bring another person into the world to have to go through what I've been through" (F2). Another father feared his child inheriting the stigma associated with psychosis: "Being diagnosed, having a label that lasts for a lifetime, is not very nice. And I don't want that for my son" (F3).

Two of the older participants had adult children who had developed psychosis, and this had led to feelings of sadness:

...my son had a breakdown when he was 24, and you can imagine the effect on me when he went the same way as me...his paranoia, his illness was exactly the same as mine when I was that age, and yet I was always told that schizophrenia wasn't hereditary.

(F1)

One father wondered if his poor relationship with his son was linked to his son blaming him for passing on his psychosis:

Well they diagnosed him as a paranoid schizophrenic...he might be blaming me... for him being like the way he is... (I feel) ...a little bit like a pariah or something like, not a pariah but a bit like a leper I expect or something like that. (F5)

For a few of the fathers, there was a concern that psychosis was a negative family legacy that would be passed down the generations: *"I feel as it goes from son to son this thing you know? ...this thing in the... family... this illness sort of thing"* (F5).

Don't let history repeat itself

A desire for history not to repeat itself was a theme which involved issues other than the inheritance of psychosis. One father had general hopes for his children's success: *"... my youngest daughter will go far as well. And I know [son] will cause I'm gonna make sure he don't end up the same way as me"* (F9). Another father wanted to pass on the

“worker” role to his children instead of the “benefit recipient” role: *“I want to...work again because I want to pass that onto my children...I don’t want to be seen as just someone that lives on benefit...”* (F8).

Domain 5: Impact of parenting on the fathers themselves

The fifth domain was: *Impact of parenting on the fathers themselves*. This was divided into: *Positives of parenting* and *Negatives of parenting*. This domain incorporates accounts of how fatherhood has had an impact on the participants themselves.

Theme 12 - Positives of parenting

Parenting was described as being accompanied by a sense of pride in the father role, a sense of purpose to one’s life, pleasure in the creation and development of life, and motivation to change for the better. Several fathers also described the attachment and bonding they felt towards their children. Participants valued the support and understanding they received from their children. Some of the participants reported that they had been overly harsh on themselves in the past with regard to their performance as fathers, and they had discovered that they were better parents than they had realised previously.

Pride in the father role

The sense of pride in being a father was a common theme for the participants. This was associated with a sense of accomplishment and achievement, in having fathered a child and in successfully raising a child:

Yeah, it made me feel proud that I have actually had a son. Acknowledge that I have got a son and that I'm not just going to be the bloke who's wandering around the age of 35 looking for a girl and never had children. (F2)

There was a sense that by becoming a parent, they had made a transition to a higher level of status, the status of “father” or “family man”: *“Well I feel proud like... I feel that I've achieved something... that's worth achieving. To be a family man and have a family” (F7).* One father described how his pride in the father role was associated with an increase in his self-confidence: *“Getting a more positive self-image really, that I had a role and I had a positive, something to contribute. So it did increase my confidence...” (F8).*

A sense of purpose

Many of the fathers described the sense of purpose and meaning that fatherhood brought to their lives. This was associated with taking on the responsibility for providing for one's children: *“...I think I'm a good dad. Cause I'm there for him, I make sure he's got clothes, I make sure he's got food...” (F9).* It appeared that the sense of responsibility felt by the fathers was associated with an awareness of their children's dependency: *“Well it goes back to the sort of responsibility thing, that...they're relying on you for everything. Especially initially they're so helpless” (F8).*

It is apparent from the following quote the incredible degree of responsibility that the fathers can feel towards their children. This particular father said that even death would not prevent him from guiding his son:

I always felt I'll enter through a spirit. Enter through [grandson's] body and try to guide him on, you know? Guide him through it. All this dying thing again, you see. Very spiritual stuff, dying you know. (F5)

Pleasure in the creation and development of life

A common sub-theme was a sense of pleasure in the creation and development of a new human being. One father talked of his role in creating new life: “...*I felt him being conceived... a very peaceful feeling came over me... I felt life being created*” (F5). A few of the fathers spoke about their pleasure in experiencing the unique qualities of each child: “*The best part was having a new individual who was someone in his own right. Quite unique to us, and special*” (F10). There was also a pleasure derived from watching one’s child develop into a self-sufficient person: “*To see them grow up and keep well and that, you know, that’s what helps me to be a father... see that they’re helping their selves...*” (F4).

Motivation to change for the better

A few of the fathers described how having children had given them the impetus to make positive changes to their lives. For one father, this meant an end to his violent lifestyle:

I don't want him to see me with broken knuckles, black eyes and all that, so I have stopped...I'm changing, cause my son's getting older. I don't want him to see that I'm doing all this...and now all he sees the last four years of me is the good side of me. Cause I'm not fighting no more... (F2)

Another father said that having a child gave him extra motivation to overcome his psychosis and the depression associated with it: “...*she's such a happy child, sort of quite life affirming. It jogs me out of the depression that used to sort of get me down...*” (F8).

Bonding

Several of the participants mentioned the attachment that they felt towards their children. One father said that when his son was born, he thought to himself: “*This is my son, my flesh and blood*” (F2). For another father, this sense of attachment began with the physical care he provided soon after his daughter's birth: “*I immediately felt, you know, attached to her. Straight away. Cause I fed her as soon as she was born*” (F8).

Support and understanding from children

Several participants described the support and understanding that their children had given them in helping them to cope with their psychosis. This included comforting words and reassurance: “*Oh brilliant, she's brilliant. When I get upset, she'll just say, 'Now... calm down, take a tablet... you'll be all right'*” (F6). The theme of support and understanding also incorporated a sense that the children felt empathy for their fathers, that they had acknowledged their father's mental illness, accepted it, understood it, and

tried to help them cope with it: *"I don't cope. I go to bed. The only thing I can do is lay in bed. Even then, [daughter] tells the kids that I'm no well, they're so quiet it's untrue"* (F6). For this particular father, the support from his children was especially important when the illness was worse: *"And when I went in [mental hospital] that time, the worst time... I thought, 'I'm sort of dead, semi-dead.' And they all come up, made love to me, you know, really close to me..."* (F6).

Reflection about evaluating self unfairly as a father

A few of the fathers reflected on their performance in fulfilling the father role. They realised that they had been too harsh on themselves in the past and they had come to a more balanced evaluation: *"...I talk to [wife] now, and she says, 'You weren't a bad dad.' I've made mountains out of molehills, but I was all right apparently..."* (F6).

Theme 13 - Negatives of parenting

The majority of the participants described negative aspects of being a father. Most relevant to this study was the sub-theme that parenting is associated with added worries and stresses which can sometimes exacerbate one's psychosis.

Parenting brings added worries and stress which can sometimes make the psychosis worse

For some of the fathers, parenting was described as being accompanied by certain anxieties, such as concern for their children's well-being: *"There's just big general worries...a lot of parents have about... about children... their physical safety... they can be happy... well-balanced people really"* (F8).

One father reported that his ex-partner had lost custody of their child due to her history of neglecting her children. He feared that she would neglect him if she regained custody: *"The fear that he might have to go into care, the fear that [son's mother] might get him in the flat and not treat him properly"* (F2). For another father, the anxieties over his children's safety were raised when his daughter had a major accident when she was a toddler: *"...she drunk some paintstripper... it burnt the whole inside of her guts... it took about 2 weeks for her to come out of hospital"* (F9).

These parental anxieties can be viewed as a burden of stress which compounds the other pressures which the participants experience. For example, one father said: *"...I'm under more stress than if I wasn't a parent...it's just more stressful being a parent than not I think"* (F8). The next quote from another participant reflects these sentiments: *"Even if I wasn't mentally ill and I was working, I suppose I still would find it difficult being a father"* (F3).

A few of the fathers described how having children around can be stressful in itself, and this stress can trigger deteriorations in one's mental state. For one father, the lack of sleep through caring for his young baby was associated with an increase in his psychotic symptoms: *"...I did struggle...I had to increase my medication after...I was telling the signs that I was getting... a bit ill through lack of sleep..."* (F8). Another father described how he had returned home after a hospitalisation for psychosis and the noise and activity of his children had caused him to return to the ward, because he could not handle the associated stress:

...4 young children... all under 5 and that, and they're flying about, large as life all the time. You know, as soon as I got home, after coming out of a quiet hospital, you know it was too much for me. I had to go back in. (F7)

Some of the fathers mentioned how childcare can be a monotonous experience at times:

"...sometimes it's just mundane because you're just changing nappies and you do it every day... the repetitive things can be a bit boring" (F8).

Some of the fathers mentioned how children can put a strain on the relationship with their partners. One father said that this strain originated in the lack of sleep in the first weeks of his child's life: *"...cause we were both lacking in sleep, there was more, there were a few arguments between me and my partner" (F8).* Another father described how his child's behavioural problems had had a negative impact on his relationship with his partner: *"...we got a kid that keeps going up and down all the time. I say I'm not gonna split my relationship" (F9).*

I've failed as a father

Some of the participants described feelings of failure in fulfilling the fathering role:

I've been ashamed of a lot of things I've done... when I made off with a lot of money and I forget the children... and I go out and go on a binge... I'd lose myself for 2 or 3 days... I would like to have been the father like every other father to their kids. (F6)

Domain 6: I need support to be a father with psychosis

The sixth domain of the interpretative phenomenological analysis was: *I need support to be a father with psychosis*. The most important source of support appeared to be the partners of the participants. It was divided into two themes: *Support from partner important in coping with child care and coping with the illness* and *What helps? What would help?*

The most important source of support appeared to be the partners of the participants. Some participants described their partners as playing an essential role in helping them to cope with their psychosis. Other participants said that their partners provided the main support to their families, for example, by being the family breadwinner or running the household. Some of the participants described how they also helped their partners in return. The other sources of support were relatives outside the nuclear family, such as parents, and the professional services. A few of the participants said that their family or their partner's family had provided help with child care or help in coping with psychosis. Professional services were viewed as being sources of support through the provision of people outside the family to talk to about problems, understanding the needs of fathers with psychosis, treating relapses in the psychosis and offering practical support.

Theme 14 - Support from partner important in coping with child care and coping with the illness

The participants described their partners as their main source of support. Partners supported the participants themselves, for example, by monitoring their mental health.

Partners took on major family responsibilities such as being the main carers for the children and being the main income earner.

Partner supports me

Some of the participants talked of the essential role their partners play in supporting them in coping with psychosis. One participant said that his wife monitors his mental state and contacts clinical services when necessary: “...*she's very knowing... she'll pick up things on me and... she's got the number that's necessary if she needs it, you know, we've got the direct link to [keyworker]...*” (F1). Another father reported that his wife held him together when he couldn't cope with his psychosis: “*I didn't cope. It was... her strong will. That's me wife. It was her strong will that held me together. It was her that kept me going*” (F6).

Partner supports the family

Some of the participants reported that their partners provide the main support to the family, taking on a range of roles such as being the main income earner and caring for the children when the participant has to go into hospital. One father, who had often been unable to work due to his psychosis, talked about his wife's financial support, which has been crucial in helping the family budget: “...*the wife stayed in work in one regular job 27 years, which has helped us like... she has supported me. Cause we haven't had a lot of money. Only sickness pay and that*” (F7). Another father talked about how his wife has taken over the complete running of the family when his psychosis has relapsed: “*She's absolutely had to take everything over and sort out the family for periods of months at a time*” (F10).

Mutual support

A few participants spoke of the mutually supporting relationships that they share with their partners, which involve helping each other with childcare and other responsibilities: *"I've got a lovely relationship... I'm in a secure relationship and we're both there for... each other"* (F9). Two of the participants mentioned the importance of communication with their partners in maintaining this mutual support: *"...we have a one to one in the evening... and we're quite happy after that like, cause we come to agreement"* (F9). Two of the fathers had partners with mental health problems, which was an extra source of anxiety: *"...if either one of us has a breakdown, a worry"* (F8).

Theme 15 - What helps? What would help?

Professional services were reported to be an important source of support for the participants. Although partners and children were part of the participants' support networks, it is of interest that only a few participants mentioned their wider families as being providers of support, and none of the participants talked of receiving support from friends.

Family

A few of the participants cited their relatives outside of the nuclear family, such as parents and parents in-law, as being important sources of support in coping with their psychosis and in the parenting of the children. One participant spoke of how his mother monitors his mental state and takes him to hospital if he is unwell: *"...me mum always know if I come ill. I don't know... she grabs me, packs me bags...she takes me up there and if they ain't got a bed there they've got to find me a bed"* (F2). This participant's

mother also took custody of his son and brought him up, as in the past, both the participant and the child's mother had been unable to care for the child themselves: *"All things that could go wrong, and then mum just blew that all out the window and said, 'I'm taking him.' And I knew he'd be safe straight away"* (F2).

Professional services - Someone to talk to

A few of the fathers said that having someone to talk to was an important way in which professional services could help them. One father felt that an increased level of contact with services in the first weeks of fatherhood would be helpful, because he found this time particularly stressful: *"...a bit more contact would be helpful, especially as it's quite a stressful time, the first year, especially the first six weeks..."* (F8).

A few of the fathers spoke of the help psychologists provide by providing someone to talk to: *"...having the opportunity to talk with a psychologist and explore ways of thinking about the situation"* (F10). Another father saw his CPN every 2 weeks for his medication, and he valued the opportunity to talk about his problems: *"Every fortnight when I have my injection I discuss it with the CPNs how exactly I feel...my CPN is always available..."* (F1).

Professional services – Understanding of needs

Some of the fathers talked about how they valued professional services understanding their needs. One father felt that the close relationship he has with his keyworker is the most important component of his professional support network:

If I've got the least bit of problem... she's the first one I phone up... she's really on the ball... she treats me normal... it's not intimate, it's really close. Do you know what I mean? Like a sister. She's really good. (F6)

Another father felt that his keyworker had a special understanding of his particular needs as a parent with psychosis because the keyworker was a parent as well: “...*they found a bed for me straight away, cause I've got a son... she (CPN) knew the aspects cause she's got children herself*” (F3).

Professional services – Support when I'm not well

Some of the participants talked about how they value the extra support they receive when they have a relapse in their psychosis. One of the participants spoke of the importance of a fast process of admission into a mental health ward should he become unwell:

And if become unwell, I do need direct access, you know what I mean? I become ill very quickly... this happens one a year, but sometimes I only go in for 2 weeks. They nip it in the bud if you know what I mean... I get straight support, I get whatever needs sorting out, I'm in there. (F2)

Another participant said that he valued the medication he receives in returning him back to health: “...*they give me... tablets... if I'm feeling a little bit down and out... to bring me back to health again. And they help out in that way, you know, which is quite useful*” (F4). One participant said that inpatient treatment provides him with a refuge when he is

unable to cope with daily life: *"Well, the inpatient treatment certainly helps me. It gives me a place to be for myself when I'm not fit to cope with external reality and I'm too focussed on my internal situation"* (F10).

Professional services – Practical support

Some of the fathers described a range of practical support from professional services which they find helpful or would find helpful in their role as parents. One participant talked about the value of having a respite from the stresses and responsibilities of parenting: *"...having a bit of time away...something outside... that I can go and do, just get out of the house for a little while to have some time away"* (F8). This participant linked such respite with the provision of a babysitter so that he could go out with his partner: *"...going out with my partner, it's nice to have a babysitter so we can go out together..."* (F8).

He found his partner's social workers had been very helpful, as they had supported his family in their application for a larger council house. The flat that they had when their child was born had been far too small for their needs: *"...my partner's had social workers, and they have been helpful... to move to a larger house... when we were trying to get moved by the council..."* (F8).

Another participant said he wished that professional services provided more support to his wife because of the stress she was experiencing as the primary carer: *"They could be giving more support to my wife as my primary carer. She comes to periods where she*

feels absolutely desperate for help, and at the time when she feels desperate, it's very rarely available" (F10).

One father said that the parent education he and his partner had received from a family centre had been very useful in learning how to raise their son: *"We had to go to a family place like where you learn about babies and kids...we had a one to one lesson with the family centre" (F9).*

Chapter Four:

Discussion

Overview

This study aimed to investigate the experiences of fathers with psychosis. Ten White/Caucasian men were interviewed, each of whom had experienced psychosis and who were biological fathers in contact with their children. The procedure involved administration of a brief demographic questionnaire, a semi-structured interview on fatherhood, the Brief Psychiatric Rating Scale (BPRS) and the Childhood Trauma Questionnaire (CTQ). The principles of Interpretative Phenomenological Analysis were used in the planning of this study and the construction of the semi-structured interview questions on fatherhood. The semi-structured interview on fatherhood was the core of the study, which was transcribed and then analysed using Interpretative Phenomenological Analysis.

Fifteen themes captured the crucial and central features of the participants' experiences. These were organised into six domains.

The first domain, *The experience of psychosis*, was made up of three themes: *Experience of psychosis*, *Psychosis originated in childhood* and *Other relevant experience*.

The second domain, *Impact of psychosis on experience of being with children*,

incorporates experiences of how psychosis has affected the father-child relationship.

This domain was divided into the following themes: *Psychosis affects ability to do the job of a parent* and *Indirect impact of psychosis*.

The third domain was: *Impact on partner*. It consists of one theme: *Psychosis has undermined my relationship with my partner*.

The fourth domain was: *Hopes and fears of fatherhood*. This was divided into the following themes: *Mixed feelings about own father*, *Negative experience of mother*, *Ideas of fatherhood before becoming a father*, *Hopes for a positive legacy* and *Concerns about a negative legacy*.

The fifth domain was: *Impact of parenting on the fathers themselves*. This was divided into: *Positives of parenting* and *Negatives of parenting*.

The sixth domain was: *I need support to be a father with psychosis*. The most important source of support appeared to be the partners of the participants. It was divided into two themes: *Support from partner important in coping with child care and coping with the illness* and *What helps? What would help?*

Findings

Psychosis is a negative experience

Participants reported many unpleasant aspects of psychosis, reflecting the experiences described by Chadwick as typical of people who have psychotic illness (Chadwick, 2002). Psychosis was distressing and destructive, sometimes causing one to withdraw from activity in order to cope. Thomas and Kalucy (2002) reported that parents with SMI may reach decisions to withdraw from their families and society in general. One possible factor in this feeling of disconnection from society is the stigma the participants experience as people with mental health problems. In Wahl's (1999) survey of the experience of stigma and discrimination among the mentally ill, over half of those in the survey said that they had felt that others had avoided them at some point. Parents with mental illness may experience discrimination in local communities leading to them feeling socially isolated and marginalized (Aldridge and Becker, 2003).

Unemployment and housing problems were experienced by many of the participants. Unemployment in particular was a common theme amongst the participants in this study. One father said that his psychosis had prevented him from working, which meant that he could not afford the mortgage payments and his home had then repossessed. These problems are well evidenced in the literature (e.g. Sands, 1995; Zemencuk et al., 1995). Employment was described as an important experience by the majority of the fathers. It is a source of pride, and the activity involved in working was mentioned as therapeutic. This links in with the prominence given to the provider role in the interviews with the fathers in the study conducted by Warin et al. (1999), where the

researchers argued that being a provider is a fundamental part of fatherhood, and the inability to provide for one's family leads to lowered confidence, frustration and sadness. Warin et al. reported that the fathers in their study appeared to express their feelings of emotional attachment to their family via the role of provider. This particular issue was unclear with regard to the sample of fathers in the present study.

Worry about finances and housing was frequently mentioned by the participants. As reported in the literature, people with mental health problems often have financial difficulties, which are often linked to the high rate of unemployment they experience. Parents with SMI may have difficulties in finding housing they can afford, and they may be forced to live in areas where accommodation is cheaper, but unfortunately the living space may be cramped and these areas may be perceived as unsafe for one's children (Sands, 1995; Zemencuk et al., 1995; Aldridge and Becker, 2003).

Psychosis undermines the father-child relationship and the work of parenting

One important effect of psychosis appears to be the way in which it undermines the relationship between the fathers and their children by precipitating a feeling of emotional disengagement from one's children. This emotional undermining of the father-child relationship is reflected in the findings of Goodman and Brumley (1990), in which mothers with schizophrenia were withdrawn and emotionally uninvolved with their children. The present study shows how fathers with psychosis are often painfully aware that they appear withdrawn from their children and they worry about the effect that this has on them. However, it is possible that the insight that they have into the undermining effect of psychosis helps them to counteract the effect of the emotional

disengagement, just as the mothers who had greater insight into their mental illness in the study of Mullick et al. (2001) displayed more sensitive mothering behaviour. A few of the fathers appeared to be concerned about how their children perceive them when they were mentally unwell. In a different but related finding, Nicholson et al. (1998a) reported that mothers with mental illness may not know how to talk to their children about the illness.

Psychosis was described as having a negative impact on one's attention and memory, which in turn affected one's ability to fulfill the father role. One participant talked of his regret that he had not been able to give his son sufficient attention during his childhood, because psychosis had had a negative effect on his concentration. Another participant described how he had had problems with his memory, which he attributed to his psychosis. He had forgotten important parental responsibilities, such as picking up his child from school, which had then led to a feeling of shame at having failed as a father. The research suggests that people with schizophrenia may experience memory problems (e.g. McKenna, Mortimer and Hodges, 1994). Clearly, these common issues for people with schizophrenia may lead to problems when one is trying to do the job of a parent.

The relapse of psychosis was an especially difficult time for the participants. For one father, relapse elicited fears that his wife, who also has mental health problems, would be unable to cope with the childcare on her own. The stress being experienced by this participant and his wife was compounded by anxiety over the possibility of losing custody. It is possible that this anxiety over losing custody following relapse may have been a factor in the relapse itself, as well as hampering later recovery (Nicholson et al.,

1998a; Bassett et al. 1999). For another participant the unpredictability of relapse was a chronic source of stress, due to the associated separation from his family. Unfortunately, this chronic stressor may have added to any vulnerabilities to psychosis he might have, increasing the chances of relapse (Zubin and Spring, 1977).

Medication was mentioned as having a negative effect on energy levels and also as being detrimental to one's ability to concentrate. Medication was also identified as a source of impairment in the ability to display emotions to one's children and it was attributed by another father as the reason he once lost consciousness while he was supposed to be caring for his son. These accounts reflect the literature in terms of the sedative effect of medication and the consequent detrimental effect on the ability to fulfil the parenting role. However, to refrain from taking medication may lead to a relapse in one's psychotic illness and a hospitalisation and separation from one's family. Clearly, medication has beneficial and detrimental effects (Nicholson et al., 1998a: Empfield, 2000).

Hospitalisation was generally a negative experience for the participants, mainly because it took the fathers away from their families. For some of the fathers, these separations were especially difficult because they had decided to limit the contact they had with their children, as psychiatric hospital was seen as an inappropriate place for children. The fathers mentioned their concerns that should their children visit, they would be exposed to a potentially dangerous and distressing environment. This view is reflected in the literature, which has mentioned how parents can be concerned about exposing children to a psychiatric ward with many distressed and unsettled patients and which is

lacking in privacy for visiting family (Thomas and Kalucy, 2002; Aldridge and Becker, 2003). Perhaps due to the “child-unfriendly” nature of adult psychiatric wards, during hospitalisations, one father had met his family in the hospital car park.

For a few of the participants, psychosis had undermined the relationship with their partner, and one father said that his psychosis had contributed to the breakdown of his marriage. This may have been associated with the burden of care the partners experienced (Aldridge and Becker, 2003). Psychosis can be a source of marital conflict which will have implications for the parenting the children receive. As McHale et al. (2002) report, families where the parents are experiencing marital conflict may be prone to hostile-competitive coparenting and imbalances in mother-father involvement with the children. At a family system level, there is greater inconsistency in the parenting children receive when their parents are having marital problems, and the consequent lack of predictability about the quality of one’s parenting may be particularly disruptive for younger children (Lauretti and McHale, cited in McHale et al., 2002).

The fathers’ childhood experiences

The majority of the participants had mixed feelings about their own fathers. Their own fathers were described as trying their best under difficult circumstances, working hard to support the family but still managing to spend time with the participants when they weren’t at work. However, these same participants also felt a lack of attention from their fathers and a sense of emotional disengagement from them. Mixed feelings may reflect a disrupted attachment to their fathers. The importance of father-child attachment is

evidenced by research indicating that the infant develops a relationship to the father independent of the relationship to the mother (Steele et al., 1996).

It is possible that the fathering the participants received was lacking in attention and emotional warmth. However, one reason for this might be that some of the participants grew up in times when less was expected of fathers. In modern times, more has come to be expected of fathers with regard to their involvement in the parenting role. It is possible that the actual quality of the fathering they had received was adequate, however as adolescents they may have been in the early prodromal phase of psychosis, and may therefore have displayed greater social withdrawal and other signs of schizotypy than in their earlier childhood. As a result, their fathers may have been experienced as emotionally disengaged and lacking in attention, either because the early stages of psychosis made the participants interpret their fathers in this manner, or because their fathers withdrew from their sons because their sons had withdrawn from them. There may have been an interaction between these two possibilities. Another possibility is that some of the participants may have selective recall of the more negative aspects of their own fathers.

Some participants reported childhoods with negative experiences involving their mothers. Some had experienced unpredictable separations from their mothers because their mothers had been hospitalised for mental health problems while one of the participants had a mother who had physically abused him. Because of the importance of the maternal attachment figure, these negative experiences must have been particularly disruptive to the attachment relationships of these participants (Bowlby, 1969, 1973,

1980; Ainsworth et al., 1978). Consequently, there was probably a great deal of damage inflicted upon the mental health of these participants. It must be noted that early separations from one's mother have not been shown to be associated with the later development of psychosis. One study investigated adults who were separated from their mothers for an average of 7 months immediately after they were born, because of tuberculosis in the family. The research found that this separation was not associated with the development of psychosis later in life (Maki, Veijola, Joukamaa, Laara, Hakko, Jones and Isohanni, 2003).

All the fathers had experienced some kind of trauma during childhood (See Table 3). There is mixed evidence that traumatic experiences and adverse experiences in one's childhood is associated with relapse of one's schizophrenia as well as rehospitallisation. One study of 354 adults with schizophrenia and schizoaffective disorder suggests that childhood traumatic experiences up to age 15, such as death or divorce of parents, separation from parents, or being hospitalised in a children's mental health unit, is associated with an increased risk of rehospitallisation. However, it must be noted that hospitalisation for mental health problems as children may imply factors other than childhood trauma in later relapse of one's psychosis as an adult. This study did not report how many of the participants were classified as experiencing trauma because they had been hospitalised for childhood mental health problems. This flaw in the study renders the findings inconclusive (Doering, Muller, Kopcke, Pietzcker, Linden, Muller, Muller-Spahn, Tegeler, and Schussler, 1998).

Drayton, Birchwood and Trower (1998) argued that people with psychosis who have had disturbed family relationships during early childhood are more likely to have had difficulty developing a secure sense of self. Their fragile sense of self is associated with having a less adequate coping style when their psychotic illness relapses. Negative childhood experiences such as physical abuse, living with a mentally ill parent, and having siblings with chronic physical illness were identified by participants as contributing to their psychosis. One study found that individuals with schizophrenia experienced both their parents as being significantly less caring than control participants (Parker, Fairley, Greenwood, Jurd and Silove, 1982).

Early ideas about fatherhood

The participants recalled what they had thought of fatherhood before their first child was born. The most prominent theme was: *Not to repeat history / to do it differently*, and several participants appeared to view their own fathers as “anti-role-models”. There was a determination not to allow history to repeat itself.

Reflecting Pruett’s (2000) theory, many of the participants had undergone a process of “reworking” in which they had decided to rework or compensate for their own early negative experiences by becoming better fathers to their own children. Many thought fathers ought to be caring and involved with their children. This reflected the study by Warin et al. (1999), in which *Being there* and *Being involved* were seen as two core characteristics of the father role. *Being there* was associated with a sense of the father’s commitment to the family and his availability should the family need to call on him for support. *Being involved* was associated with being psychologically available for the

family. Interestingly, this finding is in opposition to the results of another study which found that mothers with SMI who recalled their own mothers as detached and uninvolved have been shown to be less sensitive and adaptive parents themselves (Rogosch et al., 1992).

Hopes and fears for the children

As with the fathers in Lewis' (1986) study, many of the participants were looking forward to their children's future with hopes for their success. The participants talked of their hopes for their children's success in relationships, education and employment. However, the major concern of the participants was that they had passed on psychosis to their children. The participants appeared to place this concern above any other. This reflected the existing literature, which mentions fears of the inheritance of the genes for serious mental illness (e.g. Bassett et al., 1999; Nicholson et al., 2001). Their fears are not without basis, as the research literature, such as the Finnish Adoptive Family Study of Schizophrenia provides evidence of a genetic component in vulnerability to schizophrenia (Tienari et al., 1990; Tienari et al., 2003). Many participants experienced anticipatory anxiety, in which psychosis appeared to be a "time-bomb" which might or might not be triggered in one's children. For a few of the fathers, there was a concern that psychosis was a negative family legacy that would be passed down the generations. The inheritance of psychosis may lead to deterioration in the father-child relationship, as one father wondered if his poor relationship with his son was linked to his son blaming him for passing on his psychosis.

The impact on the children

Paternal psychosis can be seen as having a range of detrimental effects on the children of the participants in this study. Firstly there is the genetic risk to developing psychosis which children may inherit (Tienari et al., 1990; Tienari et al., 2003). Secondly, the presence of these fathers in the lives of their children is unpredictable. The risk of relapse and subsequent hospitalisation was sometimes experienced as a chronic source of stress, because of the resulting separation from one's family and concerns about childcare and in one case, a loss of child custody. This chronic stress may paradoxically increase the risk of relapse (Zubin and Spring, 1977). If the fathers are hospitalised, the resulting separation from their children may be detrimental to the child-father attachment relationship, especially if the child does not understand that the mental illness has forced the father away, and the separation was involuntary. Even when they are not separated from their families by a hospitalisation, the participants reported withdrawing from their families in order to cope with their psychosis, they reported feeling emotionally disconnected from their children, there were attention and memory problems which had a detrimental effect on childcare and one father said he had paranoid delusions about his children. Thirdly, medication for an illness which renders one emotionally disconnected from one's children was itself experienced by some fathers as an "emotional straitjacket". The relationship between the father with psychosis and his partner may deteriorate because of the mental illness, which may have a negative effect on the quality, consistency and predictability of the parenting at both dyadic and family-system levels (McHale et al., 2002).

It is possible that as a result of the way in which psychosis can directly and indirectly undermine the parent-child attachment relationship, the children of fathers with psychosis are more likely to develop a disrupted attachment relationship with their fathers. Children have been shown to develop an attachment relationship to the father independent of the relationship to the mother (Steele et al., 1996). This relationship may contribute to the mental health of the child later in life (Steele and Steele, 2001). It is also possible that the psychosis of their fathers disrupts the mother-child attachment via the negative effect of psychosis on the quality of the relationship between the father and the mother. It is acknowledged that the mother is the primary attachment figure. Perhaps the partners of fathers with psychosis experience a great deal of stress when they take on roles such as being the main income earner or being responsible for the management of the household as well as looking after their mentally unwell partners. This may consequentially have a negative effect on the quality or quantity of the parenting the mother is able to give to the children, and therefore disrupt the mother-child attachment relationship.

Beck's cognitive theories for depression, anxiety and personality disorders propose that adverse early experiences are a key factor in the later development of mental health problems. Especially important are experiences involving the parents, such as early parental deprivation or critical, rejecting parenting (Beck, 1970; Beck, Freeman, Pretzer, Davis, Fleming, Ottaviani, Beck, Simon, Padesky, Meyer, and Trexler, 1990). Many core, dysfunctional beliefs originate in early childhood experience, and are then reinforced over the course of childhood. Later, individuals who had had difficult childhoods may be more likely to develop mental health problems. With regard to the

children of the participants of this study, the unpredictability of the quality and quantity of the parenting they receive from their fathers is argued to increase the likelihood that these children will have adverse early experiences, and they may consequently develop core dysfunctional beliefs and have a greater risk of experiencing mental health problems such as depression, anxiety and personality disorders.

The impact of parenting on the fathers themselves

As in the study by Lewis (1986), the present study found that many of the participants had linked the transition to fatherhood with a change towards a more mature and responsible adult status. Like the fathers in Lewis' study, some of the participants also felt that they had joined a new social network of parents and that their social status had increased. Taking on the father role was associated with an increase in self-confidence for one of the fathers, reflecting the literature suggesting that the experience of raising children can raise the self-esteem of parents with serious mental illness (Ackerson, 2003). Many of the fathers described the sense of purpose and meaning that fatherhood brought to their lives. This was associated with taking on the responsibility for providing for one's children. The importance of the provider role reflected the views of the fathers in the study by Warin et al. (1999). Several of the participants mentioned the attachment that they felt towards their children. For one father, this sense of attachment began with the physical care he provided soon after his daughter's birth.

Several participants described the support and understanding that their children had given them in helping them to cope with their psychosis, including comforting words and reassurance and the sense that the children felt empathy for their fathers: that they

had acknowledged their father's mental illness, accepted it, understood it, and tried to help them cope with it. The value placed on support from one's children reflects what was found by the study of Zemencuk et al. (1995), in which 77% of mothers with serious mental illness listed their children as providing support. It is possible that the support and understanding from the children may have strengthened the bond between the fathers and their children (Aldridge and Becker, 2003).

A few of the fathers described how having children had given them the impetus to make positive changes to their lives. People with SMI may become self-empowered, which involves behaviours such as being proactive, confronting problems and ceasing destructive habits when they try to be better parents (Young and Ensing, 1999). Parents may experience their children as a motivation to recover from their illness because they know that they will not be able to care for their children unless they also care for themselves (Nicholson et al., 1998a; Oyserman et al, 2000). However, it must be remembered that there is the potential for parents to place their children before their own mental health (Nicholson et al., 1998a; Bassett et al. 1999).

In answer to the research question: *How do fathers with psychosis evaluate themselves in terms of fulfilling their idea of the parenting role*, a few of the fathers reflected on their performance in fulfilling the father role. Although some participants described feelings of failure in fulfilling the fathering role, others realised that they had been too harsh on themselves in the past and they had come to a more balanced evaluation. This is in line with research suggesting that mothers with mental illness may evaluate themselves unfairly in fulfilling the parenting role (Nicholson et al., 1998a).

The majority of the participants described negative aspects of being a father. Most relevant to this study was the sub-theme that parenting is associated with added worries and stresses which can sometimes exacerbate one's psychosis. In line with the literature (Nicholson et al., 1998a; Empfield, 2000), some of the fathers reported that parenting was accompanied by certain anxieties, such as concern for their children's well-being, which can be viewed as a burden of stress which compounds the other pressures which the participants experience. In addition, a few of the fathers described how simply having children around can be stressful in itself. It is possible that a relapse of psychotic illness is made more likely by the stresses of parenting adding to pre-existing vulnerabilities to psychosis (Zubin and Spring, 1977). Some of the fathers mentioned how children can put a strain on the relationship with their partners. One father said that this strain originated in the lack of sleep in the first weeks of his child's life. This too may have increased the risk of relapse. Another father described how his child's behavioural problems had had a negative impact on his relationship with his partner. Research (e.g. Nicholson et al., 1998a) would suggest that this particular father might be more vulnerable to a relapse in his psychosis because his child has behavioural problems. For example, one mother with SMI in the study found that her daughter's attention deficit disorder was physically overwhelming and she could not keep up with her because of her overactivity. This mother was probably more vulnerable to relapse because of the extra stress involved in caring for this child.

It appears that a transition to fatherhood brings with it a sense of purpose, a feeling of pride and an associated increase in self-confidence. Children are sources of support, and they are motivating factors in attempts to recover from mental illness. Fatherhood has

clearly been a positive experience which has helped to counteract the negative experiences of psychosis that the participants reported. It has made life more bearable for them. However, there are negatives to fatherhood: the added worries and stresses of being around children and having to look after them, as well as natural concerns for the children's safety and well-being. Having children can also put a strain on the relationship with the partner. These factors may result in a burden of stress which renders a father more vulnerable to relapse.

Support

The prominence of the partner

The participants described their partners as their main source of support. Some of the participants talked of the essential role their partners play in supporting them in coping with psychosis, by providing emotional support, monitoring mental health and liaising with clinical services. Some of the participants reported that their partners provide the main support to the family, taking on a range of roles such as being the main income earner and caring for the children when the participant has to go into hospital. A few participants spoke of the mutually supporting relationships that they share with their partners, which involve helping each other with childcare and other responsibilities. These diverse supporting roles of the partners of parents with SMI are well reported in the literature (e.g. Nicholson et al., 1998b; Stromwall and Robinson, 1998; Judge, 1994; Green, 2003). However, Miller (1997) notes that the married partners of mothers with schizophrenia have high rates of mental health problems, which may make it more difficult for them to provide support. Two of the participants had partners with mental health problems, which was an extra source of anxiety.

What helps? What would help?

Family

It must be noted that beyond support received from a partner or children, only a few participants mentioned their wider families, such as parents, parents-in-law, brothers and sisters, as being providers of support, and none of the participants talked of receiving support from friends. It is possible that many of the participants had poor relationships with their wider families. Nicholson et al. (1998b) investigated the views that mothers with SMI have about family members who provide them with support. It was apparent to Nicholson et al. that there were pros and cons to family support. Parents of the mothers could be helpful, but they also could be undermining, for example, by interfering with the childcare. They may also have been dysfunctional as parents to the participants, resulting in them not being trusted to provide adequate support to the child.

Professional services

Professional services were reported to be an important source of support for the participants. A few of the fathers said that having someone to talk to was an important way in which professional services could help them. One father felt that an increased level of contact with services in the first weeks of fatherhood would be helpful, because he found this time particularly stressful. The increased provision of services to new fathers may therefore be beneficial to the fathers themselves. It may also benefit services because a potential relapse of their patient's psychosis may be avoided.

Some of the fathers talked about how they valued professional services understanding their needs. One father felt that his keyworker had a special understanding of his

particular needs as a parent with psychosis because the keyworker was a parent as well. Some researchers have identified this type of special understanding as an important area in which professional services can improve their care for parents with SMI (Apfel and Handel, 1993; Mowbray et al., 1995). Fox's complaints about professional mental health services, that they are overly concerned about risk and that they ignore the positive benefits to the patient of becoming a parent, are especially relevant to interpreting the accounts of the participants in this study. Fox suggested that ongoing family treatment should be part of every care plan for mothers with a mental illness, and should include strategies to develop parenting skills, communication skills, problem-solving skills and the ability to manage stress (Fox, 1999). With regard to the participants in this study, it is argued that it is not only mothers with SMI, but also fathers with SMI who ought to be provided with these special services. The participants in this study identified many areas of need which had not been mentioned by Fox (1999). This included respite from the stresses and responsibilities of parenting via the provision of a babysitter, social workers to support families in obtaining larger housing for growing families, and extra support to partners acting as caregivers because of the stress associated with caregiver burden. As suggested by Nicholson and Blanch (1994), parenting is a valuable life role at which many people with serious mental illness can fail at if they are not given adequate support.

Methodological Issues

In order to evaluate the present study it is useful to discuss methodological issues such as sample characteristics, representativeness, quality of the data, validity and reflexivity.

Sample Characteristics

In this section, the characteristics of the sample will be discussed. These include the representability of the sample, homogeneity and heterogeneity and the quality of the interview data.

Representativeness of the sample

This section discusses how the participants in this study are similar to or different from other fathers with psychosis. My aim in this section is to situate the sample as described by Elliott et al. (1999).

Recruitment Sources

The researcher made presentations to community mental health teams, introducing the study and outlining the recruitment criteria. The keyworkers of patients meeting the recruitment criteria were asked to identify themselves to the researcher. These clinicians were then asked to introduce the research to potential participants in the course of their normal clinical duties. If a patient then expressed an interest in taking part, he was asked whether he would be prepared to enter into contact with the researcher. The nature of this recruitment strategy meant that it was not possible to know the characteristics of the

individuals who declined to participate in this study. Therefore one cannot compare the participants with the group of fathers with psychosis who did not want to take part.

Participation bias

It is possible that the individuals who decided to participate in this study had some unusual characteristics, inherent in the fact that they had agreed to talk to a stranger about intimate details of their lives. It is possible that the participants had more stable and supportive families than those who declined, as they were able to leave their children for several hours in order to take part in this research. It is also possible that the participants had fewer mental health problems than those who declined, as they were able to attend the appointment for the research interview at a clinic a distance from home.

Those who participated may have been more interested in reflecting on those experiences. The participants may have been more likely to take part because they are more articulate in describing their experiences than those who declined, either because they perceive themselves to have higher communication skills or because they were less affected by mental health problems. The ethics committee guidelines do not allow researchers to know the identity of potential participants without the consent of those participants. It is therefore impossible to approach participants directly, without the use of intermediaries such as keyworkers. It was impossible to know how many potential participants were determined to be unsuitable for this study by their keyworking clinicians, for reasons such as: poor contact with services, poor quality of relationship

with the keyworker, negative life events and perhaps in some cases, a lack of knowledge that a particular individual is a father.

There are many ways in which this study could be repeated with an adjusted recruitment strategy in order to counter the participation bias. The recruitment process might be improved by asking fathers who have participated to take copies of the patient information sheets and introduce the study to other potential participants. This might lead to the recruitment of individuals who otherwise might not take part. The interviews could be conducted in the homes of participants, so that they are able to take part without leaving their families behind, and they would not have to travel to the clinic. The data collection covered a period of about five months. This could take place over a longer period of time so that individuals who are mentally unwell are more likely to have recovered and thus be able to participate in the study while the data collection period is still in progress.

Potential participants who were less articulate because of their self-perceived poor communication skills may have been more likely to be recruited if the patient information sheet was made more simple. It is unfortunate that the criteria of ethics committees require a great deal of information on the study to be contained on the patient information sheet. It is acknowledged that the participants must know what they are participating in, and they must know their rights. However, it is possible that the volume of information on the patient information sheet may discourage some individuals from taking part in the study.

With regard to the effect of the keyworkers in the recruitment process, it is possible that the use of keyworkers as intermediaries could be bypassed by the placement of advertisements for the study in appropriate locations, such as the clinic, and local mental health charities. Another way in which the use of intermediaries might be avoided would be to hold presentations of the study in appropriate venues such as local mental health charities and then to ask for those present to take part.

Ideally, if this research study was to be repeated, the recruitment design would incorporate all the above strategies in order to increase the number of participants and the variation in the sample. The recruitment process might involve asking participants to help recruit further participants, the interviews could be conducted in the homes of participants, the data collection could take place over a longer period of time, advertisements for the study could be placed in appropriate locations, and presentations of the study might be given in appropriate venues.

Heterogeneity and homogeneity of the sample

The participants all had a diagnosis of a psychotic-type disorder. However they had a range of mental health problems within this criterion, such as schizophrenia, delusional disorder and schizoaffective disorder. All the participants were White-British, all were in contact with their children and all were biological fathers of their children. However they varied in many ways: in terms of age, number of children, age of their children, whether they became fathers before or after the onset of their psychosis, and the time elapsed since that onset. They differed in marital status, family living arrangements,

employment status, education, religious affiliation and experience of imprisonment. In addition, four were grandfathers and one of these men was also a great-grandfather.

This study is probably the first investigation into fathers with psychosis at this level. It was useful to have a heterogeneous sample because the research could identify a diversity of experiences and ideas for further research. This study could be repeated with different populations and possibly with different methodologies where one could use a greater number of participants and a greater level of homogeneity, so that more conclusive findings are possible.

It is difficult to measure how the ethnic homogeneity of the sample impacts upon the data from this study, with regard to the experience of fatherhood and the experience of psychosis. Other research suggests difference and diversity between ethnic backgrounds may have a strong impact on attitudes to parenting (Townsend, 2002; Gadsen et al., 2004) and attitudes to mental illness (Warner, 2004). Therefore the participants may all share certain beliefs about fatherhood and psychosis because they share their ethnic background. The findings from this study may therefore be limited to White-British fathers with psychosis. The study needs to be repeated to investigate the experiences of fathers with psychosis from other ethnic backgrounds, for example, African-Caribbean fathers, and Asian fathers. It is possible that the participants all shared a quality or set of qualities which influenced them in maintaining contact with their children, and this quality is not shared with fathers who are not in contact with their children. The findings of this study are therefore limited to those fathers who are in contact with their children.

The study needs to be repeated to incorporate the experiences of fathers with psychosis who are not in contact with their children.

The participants were all biological fathers of their children. It is possible that men with psychosis who are step-fathers or foster fathers might have different attitudes to fathering and psychosis. The findings of this study are therefore limited to those men who are biological fathers. This research needs to be repeated to research men with psychosis who are step-fathers and men with psychosis who are foster fathers. Due to the relative homogeneity of the diagnoses of the participants, the findings of this study are limited to individuals with psychosis, and cannot be applied to those who are fathers but who have other diagnoses such as chronic mood disorders or personality disorders. The study might be repeated with fathers who have other diagnoses.

In summary, the heterogeneity of the sample was useful in generating ideas for further research. The homogeneity of ethnicity, diagnosis, contact with children and biological fathering status means that this study requires replication to investigate other groups of fathers. The study could be repeated to investigate fathers with psychosis from other ethnic backgrounds, fathers with psychosis who are not in contact with their children, men with psychosis who are step-fathers or foster fathers and also fathers who have other diagnoses.

Quality of the interview data

The majority of the participants communicated clearly and in detail about their experiences of being fathers with psychosis. However, a few of the participants were less able to provide a detailed, articulate account of these experiences. While this is to be expected in any sample, it is possible that the mental health problems of participants may have rendered them less able to recall or to communicate their experiences. For example, the BPRS interview suggested that the majority of the fathers had anxiety problems to some degree, two of the fathers had a severe level of unusual thought content, four of the fathers had a degree of suspiciousness and two of the participants were experiencing hallucinations around the time of interview. Half of the participants had a depressed mood to some degree. Participants with anxiety or depression may have found it more difficult to talk about their experiences, or they may have been more likely to recall more negative experiences or concerns, and less likely to recall more positive experiences or hopes. Suspiciousness may have led to participants being less willing to talk about their experiences with the researcher, thereby decreasing the quality of the interview data. The unusual thought content and hallucinations of some of the participants may have influenced the accounts of their experiences. Therefore, the data which was obtained might have been of a different quality than if these participants had not had unusual thought content or hallucinations.

Validity

I shall use validity as Stiles (1993) suggests, as a concept "...which addresses the trustworthiness of the interpretations of conclusions drawn from the data". Judging the

quality of qualitative research is an important process which is discussed in several articles and books (e.g. Elliott et al., 1999; Willig, 2001; Smith, 2003). “Good” qualitative research should involve researchers disclosing their own values and assumptions, participants should be described in detail, interpretations should be “grounded” in examples from the original data, other researchers should provide credibility checks, analyses should be presented coherently, and the aims of the study should be explicit (Elliott et al., 1999).

The sample was therefore situated by describing the recruitment process and the participant characteristics (Elliott et al., 1999). The analysis has been described in Chapter Two and the interpretation of the data has been grounded in examples (Elliott et al., 1999). Credibility checks on the analysis were conducted, in which a second researcher, an expert in IPA, conducted a data audit and an analysis audit, in which codings were tested by returning to the original data. There was an examination of how specific evidence was described in wider frames, and some categories were discussed and changed in agreement between the two researchers (Elliott et al., 1999; Willig, 2001). The aims of the study were made explicit at the end of Chapter One, while the results of the analysis were presented coherently in Chapter Three. The values and assumptions of the researcher were described in Chapter Two and their impact on the results are now discussed.

During recruitment, it is possible that being a Chinese-white middle class male may have influenced the keyworkers perception of me, and this may itself have influenced their willingness to act as intermediaries in the recruitment process, positively or

negatively. I am not a father myself, and my ability to interpret the accounts of the participants is probably different to the way in which I would interpret if I was a father. Prior to the interviews, I had read literature on fatherhood and psychosis, which probably influenced my attitudes towards the participants. Throughout the interviews I tried to remain respectful and non-judgemental. During the interviews, I was aware that my own expectations and beliefs might influence the course of the participants' accounts. I therefore tried to interrupt their answers as little as possible. When I did interrupt the participants, it was mainly due to time pressures. However, it was inevitable that the probe questions, in which participants were asked to elaborate on their accounts, were influenced by my beliefs and attitudes. In addition, my presentation as a male researcher, a mental health professional, and someone who was younger than the participants may have influenced how they perceived me, and therefore how they responded to the interview questions. For example, because I was seen as a mental health professional, the participants may have been less comfortable in describing ways in which services might be failing them in supporting them in their roles as fathers.

In the semi-structured interview, the use of certain specific questions may have prompted participants to report on experiences which were less salient to themselves. The implication of this is that the prior concerns of the investigator may have influenced the themes obtained from the fatherhood interviews. The participants may not have reported certain experiences had they not been prompted to do so. With regard to future research using Interpretative Phenomenological Analysis, the design of the semi-

structured interview schedule would be improved by eliminating specific questions and replacing these with more neutrally worded questions.

The evaluation of how these factors have influenced the data obtained in this study is very difficult. However, the credibility checks conducted by the second researcher are likely to have helped to minimise the researcher bias. The grounding of the findings in quotes from the verbatim transcripts allows the reader to link the interpretations of the researcher with the original accounts of the participants.

Clinical Implications

The findings from this study will be presented to the participating service teams, along with recommendations of how the fathers with psychosis on their caseloads might receive improved support. The recommendations are based on the conclusions from the interview data, but they also incorporate the researcher's experience during the recruitment and data collection process. For example, at the time of the recruitment, there were no official records kept of which clients were fathers and which were not. This indicates that the needs of fathers with psychosis have possibly been neglected in the minds of mental health services.

The recommendations include:

1. Services should have a greater awareness of which of their male clients with psychosis are fathers. Services need to take fatherhood status into account in their care planning. Fatherhood may have positive and negative effects on the

mental health of these clients. Psychosis has a mainly negative effect on their experience of fatherhood.

2. Services need to examine the provision of extra services to fathers with psychosis and their families. For example, special childcare services and child-friendly inpatient units. Services need to ask fathers with psychosis specific questions about what support they or their families may need.
3. Male clients with psychosis should receive extra support from services during the first months of fatherhood, as the stresses associated with parenting may have a negative impact on their mental health.
4. Services should have a greater awareness of the direct and indirect effects of a parent's psychosis on the mental health of the partner and children.

At a later stage, it is aimed to publish this study, so that the findings can be disseminated to more service professionals. It is hoped that a greater number of clinicians will have an increased awareness of the needs of fathers with psychosis and their families.

The findings and recommendations of this study will also be shared with the participants. This may be a normalising opportunity for the participants, helping them to feel that other fathers with psychosis and mental health services understand their needs and concerns.

Directions for further research

This study was designed to explore the experiences of fathers with psychosis and to identify avenues for future research with this group. There are many possible avenues for further research besides the replications of the study mentioned earlier in this discussion. Future research might involve a much larger sample size, investigating fathers of certain age groups and ethnic backgrounds, for example, African-Caribbean fathers with psychosis under 25. Fathers with psychosis could be investigated in a larger scale study using quantitative and qualitative methods. For example, 200 fathers with psychosis might be administered quantitative parenting measures, personality disorder inventories, quality of life inventories as well as mental health instruments. Such a study might investigate fathers with psychosis to explore associations between perceived quality of life, severity of one's mental health problems, presence of personality disorders, sensitivity to the needs of one's children, and the parental style of one's own parents. A random sample of 20 of these participants could be interviewed in a detailed semi-structured interview on their experiences, to be analysed qualitatively. A random sample of these participants might be administered an adult attachment interview, and thoughts and feelings about attachment relationships could be compared with other data such as the sensitivity to the needs of one's children and the presence of personality disorders.

There could be research into the group process in families of fathers with psychosis, to investigate family system level interactions. The young children of fathers with psychosis could be studied with regard to their experiences, and then a series of

longitudinal studies could follow them as they grow into adults. An experimental service could be developed, incorporating special support for fathers with psychosis and their families, such as increased contact with keyworkers following the birth of children, parent training programmes and respite childcare arrangements. The mental health of the fathers and the families of this programme could be monitored before and after the provision of such a service.

Conclusion

This study set out to answer a number of research questions. With regard to the results of this research and taking into account the discussion of how these results relate to the existing literature, as well as the methodological issues outlined earlier, the answers to these questions are now summarised:

What is it like to be a father with psychosis?

This study found that psychotic illness has a negative effect on the experiences of fathers. It undermines the father-child relationship and the work of parenting. However, in the process of fulfilling the role of fatherhood, men with psychosis benefit from a sense of pride in the father role, a sense of purpose to one's life, a feeling of pleasure in the creation and development of life, and motivation to change for the better.

How do fathers with psychosis evaluate themselves in terms of fulfilling their idea of the parenting role?

Some fathers with psychosis may feel that they have failed as parents, and these failures may be attributed in part to perceptions of how the symptoms of psychosis have affected them in their performance as parents. However, some fathers with psychosis recognise that they have evaluated themselves unfairly, and they have realised that their parenting is of a better quality than they previously thought.

Do fathers with psychosis have fears of passing on the illness to their children?

The fear of one's children inheriting psychotic illness is a widespread concern amongst fathers with psychosis. The illness is experienced as a "time-bomb" which may or may not be triggered in one's children. For fathers with psychosis, this fear incorporates a concern that one's children will have to suffer the same negative experiences they themselves have.

Do fathers with psychosis have fears of losing custody of their children?

Loss of custody did not appear to be a common fear amongst fathers with psychosis. This is an unexpected finding, which may possibly be explained by the older age of many of the participants, which meant that their children had already reached adulthood, or there might be a participant bias which is associated with having less fear of losing custody of one's children. Further research could be conducted to clarify this finding.

Do fathers with psychosis experience feelings of blame, guilt or shame in association with fears of passing on the illness or losing custody?

It was unclear whether this question was answered by this research. Some participants mentioned the distress that passing on psychosis to the children would cause them. Two of the participants reported on the distress they had experienced when their children had developed psychosis. One of these participants said that the poor relationship he had with his child might be attributed to his child blaming him for passing on his psychosis. However, there were few explicit accounts of feelings of blame, guilt or shame in the data obtained by this study. One father did report that he had a sense of shame and failure when he had forgotten important parental responsibilities, such as picking up his child from school. Another father reported feeling shame that he had forgotten about his children and left his family for two to three days when he went on a binge.

How do the absences arising from hospitalisations for the illness affect caregiving arrangements, the relationship with the children and with the partner?

Hospitalisations appear to have an undermining effect on the father-child relationship because of their unpredictability and the separations they involve. This study found that during hospitalisation, childcare is usually conducted by the partner of the father with psychosis, which may have a negative effect on their relationship, and possibly as a consequence, an indirect effect on the child. Partners who have mental health problems themselves may find hospitalisation of the father with psychosis especially difficult to deal with.

Overview

This is the first study which has examined the experiences of fathers with psychosis in detail. This study found that psychosis may directly and indirectly undermine the father-child relationship and the work of parenting. The fear of one's children inheriting psychotic illness is a widespread concern amongst this group. In the process of fulfilling the role of fatherhood, men with psychosis benefit from a sense of pride in the father role, a sense of purpose to one's life, a feeling of pleasure in the creation and development of life, and motivation to change for the better.

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APPENDICES

Appendix 1: Ethical approval and project registration

Appendix 2: Staff information sheet

Appendix 3: Participant information sheet

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Appendix 5: Semi-structured interview schedule

Appendix 6: Brief Psychiatric Rating Scale

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Appendix 9: IPA Stage 1: Noting emerging theme titles in the right margin.

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Appendix 11: IPA Stage 4: Consolidating master lists of each interview into a list of master themes.

Appendix 12: IPA Stage 5: Communicating the final list of master themes in the form of an account illustrated by quotes from the transcripts.

Appendix 1: Ethical approval and project registration

Hounslow District
Local Research Ethics Committee



Clinical Effectiveness Unit
First Floor, Percy House
West Middlesex University Hospital
Twickenham Road
Isleworth
Middlesex, TW7 6AF

Tel.: 020 8321 5520

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Mr Erik Evenson
Trainee Clinical Psychologist
Sub-Department of Clinical Health Psychology
University College London
1-19 Torrington Place
London WC1E 6BT

16 July 2003

Dear Erik

Re: An investigation into the experiences of fathers with psychosis (LREC Ref. No. 03/756/SV)

Thank you for your letter of response to the issues raised by the Committee in respect of the above-named study and associated amendments, which the Committee considered at its last meeting on Monday 14 July 2003, when **your proposal was granted local ethical approval.**

Please see the enclosed Approval Form for a record of all the documents approved with their dates of approval.

This approval, and the collection and/or retrieval of information from notes, databases, routine statistics or in person, is subject to the obtaining of written or otherwise demonstrable participant consent, in accordance with the Data Protection Act, and ensuring participant confidentiality and sensitivity at all times, and to the standard conditions of approval, which are given on the enclosed sheet.

Please contact the above office if you have any queries. Please would you also let the above office know of any further amendments and/or adverse events, quoting the above LREC reference number in all future correspondence.

On behalf of the Committee, I wish you well in your study and look forward to hearing what results you obtain.

Yours sincerely

Jacob Leveridge
Administrator, Hounslow District LREC

26 August 2003

Dear Erik Evenson

Re: An investigation into the experiences of fathers with psychosis

I am pleased to confirm that the above project has received Trust R&D approval, and you may now commence your research.

May I take the opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold a Trust/NHS contract (honorary or full) are allowed contact with Trust patients. If you do not hold a contract please contact the R&D Office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D Office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D Office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D Office.
- **Publications:** it is essential that you inform the R&D Office about any publications which result from your research.

We would like to wish you every success with your project.

Please would you send us a copy of your ethics approval letter as soon as you receive it.

Regards

Maria Tsappis
R&D Administrator



Barnet, Enfield & Haringey Local Research Ethics Committee

Holbrook House,
Cockfosters Road,
Barnet EN4 0DR.
Herts.

Tel: 020 8272 5699
Fax: 020 8272 5691

Email:

5th February 2004

Mr. E. Evenson,
Sub-Dept of Clinical Health Psychology,
University College London
1-19 Torrington Place,
Gower Street,
London WC1E 6BT.

Dear Mr. Evenson,

03/154: The experiences of fathers with psychosis

Acting under delegated authority I write to acknowledge receipt of your letter dated 2nd February 2004 and the enclosed clarification requested by the LREC in our letter to of the same date. There is now no objection on ethical grounds to the proposed study. I am therefore happy to give you the favourable opinion of the LREC:

Paperwork reviewed
LREC application form
Protocol
Patient Consent form
Patient Information sheet
GP/consultant information sheet
CV of lead researcher
Finalised questionnaire

Please note that this opinion alone does not entitle you to begin research

The Barnet, Enfield & Haringey LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. **It is the NHS body, which has the responsibility to decide whether or not the project should go ahead,** taking into account the ethical advice of the LREC. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management who will need to be assured that the researcher holds an appropriate NHS contract and that indemnity issues have been adequately addressed.

The following conditions apply to this project

- The LREC will require a copy of the final report on completion of the project and require details of the progress of the project periodically (i.e. annually for longer projects)
- The committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.
- If data is to be stored on a computer in such a way as to make it possible to identify individuals, then the project must be registered under the Data Act 1998. Please consult your department data protection officer for advice.
- Failure to adhere to these conditions set out above will result in the invalidation of this letter of no objection.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Please forward any additional information/amendments regarding your study to the LREC Co-ordinator at the above address.

Your application has been given a unique reference number 03/154, please use it on all correspondence with the LREC.

Yours sincerely

Alison O'Kane
LREC Co-ordinator
Barnet, Enfield & Haringey

Barnet, Enfield and Haringey



Mental Health NHS Trust

**R & D DEPARTMENT
ST. ANN'S HOSPITAL
ST. ANN'S ROAD
LONDON N15 3TH**

E-mail: research.department@beh-mht.nhs.uk
Direct Line: 020 8442 6503

28 February 2004

Mr Erik Evenson
84 Trevelyan Road
London SW17 9LN

Dear Mr Evenson,

03/154: The experiences of fathers with psychosis

I am pleased to note that you have received the favourable opinion of the Local Research Ethics Committee for your study.

All projects must be registered with the Research Department if they use patients, staff, records, facilities or other resources of the Barnet, Enfield and Haringey NHS Mental Health Trust.

The R&D Department on behalf of Barnet, Enfield and Haringey NHS Mental Health Trust is therefore able to grant approval for your research to begin, based on your research application and proposal reviewed by the ethics committee. Please note this is subject to any conditions set out in their letter dated 5 February 2004.

You are obliged to adhere to the research governance framework as set out by the Department of Health Research Governance Framework for Health and Social Care*.

It is required that all researchers submit a report of the project and copies of all publications emanating from the study to the R&D Department. Furthermore, all publications must contain the following acknowledgement.

"This work was undertaken with the support of Barnet, Enfield and Haringey NHS Mental Health Trust, who received "funding" from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".

"a proportion of funding" where the research is also supported by an external funding body; "funding" where no external funding has been obtained.

Best wishes, and look forward to hearing from you in the future.

Yours sincerely,

Gerard Leavey
Assistant Director R & D

*Further information on research governance can be obtained on the DH web pages at <http://www.doh.gov.uk/research/>

Appendix 2: Staff information sheet

'An investigation into the experiences of fathers with psychosis'

Erik Evenson and Dr. Janet Feigenbaum, Sub-Dept of Clinical Health Psychology, University College London; John Rhodes, St. Ann's Hospital; Anna Solly, West London Mental Health Trust

The benefits of this research will be that the NHS will have more detailed information with which to plan services for fathers with psychosis and their families. Such service benefits might include informing the further development of special programmes for parents with mental illness.

This is a qualitative study, in which participants will be interviewed once. The study will involve the interview of twelve to fourteen men. Participant selection will be by means of writing to consultant psychiatrists, informing them of the nature of the study and requesting the name of the clinician / person directly responsible for the care of male patients who meet the following criteria:

- **Fatherhood.**
- **A diagnosis of psychosis (schizophrenia, schizoaffective or other psychotic disorder).**
- **White/Caucasian ethnicity.**
- **Aged 18 or over.**
- **Individuals who are stable with regard to their mental state, i.e. patients who are on remission/maintenance treatment.**

The researcher will then meet with the clinician / person directly responsible for the patients' care, the nature of the study will be explained and the clinician / person will be requested to make first contact with potential participants with a view to their possible recruitment into the study. Then, if patients are willing to participate, they will either contact the researcher directly or the clinician in question will, with their consent, forward their contact details to the researcher. The researcher will then give them the Patient Information Sheet and Consent Form and formally recruit them to the study.

The clinician will be asked to approach only individuals who have met the above criteria and who also meet the following criteria:

- **Fathers who have contact with their children.**
- **Natural (biological) fathers of children, not step-fathers or foster fathers.**

The fathers will be informed of the study by their keyworkers in the course of their normal contact with mental health services.

Rationale for sampling criteria:

- The collection of data from fathers with a diagnosis of psychosis who have contact with their children is essential to achieve the aims of this study.
- The sampling is to be limited to those of White/Caucasian ethnicity. This is necessary because difference and diversity between ethnic backgrounds may have a strong impact on attitudes to parenting and men's experience of fatherhood and their mental illness. Limiting the study to interviews of members of one ethnicity will help to prevent the outcomes of the study from being confounded by ethnicity factors. The interview of fathers with psychosis from other ethnic backgrounds would be an aim of future research.
- The sampling is to be limited to those who are natural (biological) fathers of children. This is because differences between natural fathers and those who are step-fathers or foster fathers may confound the analysis of the results from this study. The interview of men with psychosis who have a different type of fathering role would be an aim of future research.

Data collection

If a potential participant is interested in taking part in the study, the researcher will arrange to meet him at a mutually suitable time and place. The researcher will ensure that each participant has been given an information sheet and understands the nature and purpose of the study, his right to withdraw from the study at any time, the mechanisms in place should he become distressed by the research, what will happen to the data collected and that the interview will be taped. Participants will be offered ten pounds for their time.

It is hoped that the participants will not find any of the interviews distressing. However, should a participant become distressed or show signs of becoming distressed during the interview, the interview will be halted and support will be offered by the interviewer, Erik Evenson. The participant will have the choice of withdrawing from the study, resuming the interviews after a break or continuing at a later date. If a participant needs some further support because of distress from the interviews, he will be informed that he can talk to his keyworker and/or Anna Solly or Erik Evenson on a telephone number provided. The keyworker will be informed of the participant's distress. All patients will be under the care of an R.M.O. who is well placed to implement further support mechanisms if required.

If a participant has any complaints, he will be informed that he may either contact Anna Solly or Janet Feigenbaum on the telephone numbers provided.

The data will be collected by means of two measures, the Brief Psychiatric Rating Scale (BPRS) and the Childhood Trauma Questionnaire (CTQ), a brief demographic questionnaire and a semi-structured interview on fatherhood.

Appendix 3: Participant information sheet

West London Mental Health



NHS Trust

INFORMATION SHEET

'The experiences of fathers with psychosis'

Erik Evenson and Dr. Janet Feigenbaum, Sub-Dept of Clinical Health Psychology, University College London;
John Rhodes, St. Ann's Hospital; Anna Solly, West London Mental Health Trust

What is this all about?

You are being invited to take part in a research study.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information very carefully and discuss it with friends, relatives and your keyworker if you wish.

Please feel free to ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The organisation Consumers for Ethics in Research (CERES) publishes a leaflet entitled Medical Research and You. This leaflet gives more information about medical research in general and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

Thank you for taking the time to read this.

What is the purpose of the study?

We are conducting a study to find out more about what it is like to be a father with psychosis.

We are doing this because fathers with psychosis have often been ignored by the researchers, and it is important to know more about them. We want to understand how having psychosis has influenced the way you feel as a father, how your children think of you and how you spend your time with them.

The research will help the NHS to plan services for fathers with psychosis and their families.

The NHS recognises that parents require more help. (Falkov, 1998) More parenting programmes are needed and this research would inform the development of such programmes.

The study will last until June 2004.

Why have I been chosen?

You are being given this information sheet because you are a father and you have been given a diagnosis of psychosis. About fourteen men who are fathers with a diagnosis of psychosis will be interviewed.

Do I have to take part?

This study is not part of normal treatment. You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. Your decision to take part or not will not affect your care in any way. Taking part in this research will not interfere in any way with normal treatment nor affect any decisions subsequently made by any service. If you do decide to take part you will be asked to sign a Consent Form.

If you decide to take part, you'll be invited to spend an hour and a half with Erik, the researcher. You will be offered ten pounds for your time. The interview will ask you some questions about your illness, some questions about your own upbringing and childhood, including any traumatic childhood experiences, and some questions about what it is like to be a father.

What do I have to do?

What are the possible benefits of taking part?

What if something goes wrong?

**If you have any complaints, you may either contact Anna Solly on
or Janet Feigenbaum on Tel:**

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you that leaves the hospital/CMHT will have your name and address removed so that you cannot be recognised from it.

All data will be labelled with a number in order to preserve anonymity. Any publications that arise from this study will not identify individuals in any way.

The results of the research will be written up for a report. The results may be published in about two years time. If you want to get a copy of the results, please tell Erik when you meet him.

- 1. Erik Evenson** Tel: _____ or Mobile _____
or write to: **Sub-Department of Clinical Health Psychology, University College London,**
Gower Street, London, WC1E 6BT
- 2. The second person to contact (if you cannot contact Erik Evenson) is Anna Solly, a clinical supervisor for this project, working in West London Mental Health Trust. Tel:** _____
- 3. Janet Feigenbaum, research supervisor for this project, who can be contacted about research. Tel:** _____

19.8.03 Version 3

Appendix 4: Study consent forms

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: The experiences of fathers with psychosis

Name of Researcher: Erik Evenson

Please initial box

1. I confirm that I have read and understand the information sheet dated
(version) for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving any reason, without my medical care or legal rights being affected.

☐

3. I understand that sections of any of my medical notes may be looked at by responsible
individuals or from regulatory authorities where it is relevant to my
taking part in research. I give permission for these individuals to have access to my
records.

☐

4. I agree to take part in the above study.

☐_____
Name of Patient_____
Date_____
Signature_____
Name of Person taking consent
(if different from researcher)_____
Date_____
Signature_____
Researcher_____
Date_____
Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

'The experiences of fathers with psychosis'

Erik Evenson and Dr. Janet Feigenbaum, Sub-Dept of Clinical Health Psychology, University
College London; John Rhodes, St. Ann's Hospital; Anna Solly, West London Mental Health Trust

**CONSENT TO RELEASE RECORDINGS: (note: one copy for researcher,
one copy for volunteer to keep)**

CONFIDENTIAL

The reason we are recording is to better our understanding of what you have said; we use the tapes to listen carefully and repeatedly to each interview. When we publish our findings, it is often useful if we can include word for word extracts from the interviews (with names and other identifying information removed).

Please circle 'Yes' or 'No' for the statement below:

1. I give consent for all or part of the transcript of my interview to be published in scientific journals or books.

Yes / No

If you have any questions about anything on this form please ask Erik Evenson,
Researcher, on 07941-906-505

Name of Patient

Date

Signature

Researcher

Date

Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

Appendix 5: Semi-structured interview schedule

Date: _____ Centre Number: _____ Study Number: _____

Patient Identification Number for this trial: _____

Prompt the patient to comment on the PIF and the consent form.

Demographic Questionnaire

I am going to ask you some short questions about yourself and your children, do you have any questions?

Date of Birth: _____ Self-reported ethnicity: _____

Number of children: _____

Child 1	Child 2	Child 3	Child 4	Child 5
Age	Age	Age	Age	Age
Gender M / F	Gender M / F	Gender M / F	Gender M / F	Gender M / F
Freq. of Contact	Freq. of Contact	Freq. of Contact	Freq. of Contact	Freq. of Contact
Custody	Custody	Custody	Custody	Custody
Lives with father?	Lives with father?	Lives with father?	Lives with father?	Lives with father?

Marital Status: _____

Family Living Arrangements: _____

Highest Educational Attainment: _____ Occupation: _____

Religion: _____

What services do you receive for your health? _____

How often do you receive these services? _____

Have you ever been to prison? _____

Date: _____ Centre Number: _____ Study Number: _____

Patient Identification Number for this trial: _____

Fatherhood questionnaire

I am going to ask you some questions about what it is like to be a father who has psychosis and some other questions about your family. Do you have any questions?

To start with, I'm going to ask you about changes over your lifetime, starting from when you were a child.

QUESTION 1.

i) Before you had a child, did you have a picture or idea of what sort of father you wanted to be? What was that idea?

ii) When you did have a child, what was that like for you?

iii) What was the best part and what was the worst?

iv) Did it change in any way what you thought of your self?

v) When you became ill, how did that change you as a father? Eg, your thoughts, feelings, or behaviours?

vi) How old were you when you first received a diagnosis of psychosis?

vii) How old were you when you first became a father?

QUESTION 2.

What is it like now being with your children?

QUESTION 3.

a) Has your illness made it easier for you to be the sort of father you thought fathers ought to be?

b) Has your illness made it harder for you to be the sort of father you thought fathers ought to be?

QUESTION 4.

- a) As a father, what hopes do you have about your future?
- b) As a father, what concerns do you have about your future?
- c) As a father, what hopes do you have about your child / children's future?
- d) As a father, what concerns you have about your child / children's future?

QUESTION 5.

- a) As a father, how do you cope when you're not feeling well?
- b) When you are unwell how do you cope?
- c) How do services help when you are unwell?
- d) How could services help when you are unwell?

QUESTION 6.

I am going to ask you about your own father now...

When you were young, say about 10, what was your father like to you?

How much time did your father spend with you when you were a child?

Up to the age of 18, did you father live with you? _____

(If not) when did he leave? _____

Highest Educational Attainment of father: _____

Occupation of father: _____

Did your father have a mental illness? _____

QUESTION 7.

What helps you to be a father with your children; and what does not help?

QUESTION 8.

How could the hospital and community services help you in your role of a father?

OTHER QUESTIONS

What is it like to be a dad with psychosis? What are the good parts and the bad parts?

When you're with your children what does that feel like?

When you tell people you're a father, what does that feel like?

What helps you to be a dad with your children?

How is it difficult, what makes it easier?

When were you were first ill, take your mind back to x time before that , what did you think fathers should be like?

Thank you for taking part. How has the interview felt for you? Do you have any questions you want to ask?

Appendix 6: Brief Psychiatric Rating Scale

Questionnaire removed to protect security of test materials

Appendix 7: Childhood Trauma Questionnaire

Questionnaire removed to protect security of test materials

Appendix 8: Letter to consultants

Dr X
X

XX.XX.XX

Dear Dr. X.,

Re: 'An investigation into the experiences of fathers with psychosis.'

Erik Evenson and Dr. Janet Feigenbaum, Sub-Dept of Clinical Health Psychology, University College London;
John Rhodes, St. Ann's Hospital; Anna Solly, West London Mental Health Trust

We are writing to inform you of research we are conducting to investigate the experiences of fathers with psychosis.

This study aims to investigate the experiences of fathers with psychosis. The benefits of this research will be that the NHS will have more detailed information with which to plan services for fathers with psychosis and their families. Such service benefits might include informing the further development of special programmes for parents with mental illness.

We are seeking the participation of a small sample of male patients who meet the following criteria:

- Fatherhood.
- A diagnosis of psychosis (schizophrenia, schizoaffective or other psychotic disorder).
- White/Caucasian ethnicity.
- Aged 18 or over.
- Individuals who are stable with regard to their mental state, i.e. patients who are on remission/maintenance treatment.

Please spare a moment to review the patients under your care who might be suitable for our study. If you know of any patients who meet these criteria and to whom you are R.M.O. would you be willing to pass on the names of their

designated keyworkers? This would allow us to approach the keyworkers about the possibility of their patient(s) participating in our study.

Each participant would be interviewed once for a period of about one and a half hours. The interviews will be taped to aid their analysis. Participants will be paid ten pounds for their time.

We attach a copy of the research protocol, patient information sheet and consent forms. If you have any questions about the study, please feel free to contact Erik Evenson on _____ or e-mail:

Yours sincerely,

Anna Solly
Clinical Psychologist

Erik Evenson
Trainee Clinical Psychologist

This research study has been approved by the Hounslow District Local Research Ethics Committee and registered with the West London Mental Health R & D Consortium.

Appendix 9:

IPA Stage 1: Noting emerging theme titles in the right margin.

IPA Stage 1:

Noting emerging theme titles in the right margin.

(Extract from transcript of F8)

Q: What was tiring?

Lack of sleep for father + partner.

A: The lack of sleep. Cause we were sharing, you know. Me and my partner were sharing, sort of feeding her, cause she was bottle fed. Tiring but at the same time it sort of gave you a purpose, gave you a bit more of a purpose, for life outside of... it seemed more important than anything else really, that had happened previously.

New sense of purpose.

Purpose more imp't than being tired.

Q: So it seemed more important than anything else that had happened before in your life. Can you tell me any more about this purpose?

A: Well it goes back to the sort of responsibility thing, that you're, they're relying on you for everything. Especially initially they're so helpless. Well, they come across that way. It just gives you a reason to get up. You know. It just snaps you out of any sort of depression or worry. Not worry, but especially you don't have time to sort of worry about things that might have been preoccupying, you know, before you had a baby.

Sense of responsibility heightened by child's helplessness.

A reason to get up.

Children -> lack of time -> snaps you out of depression or worry.

Q: Right, right. So life changed quite a bit for you.

A: Yeah.

Q: Ok. Oh, by the way when I ask this stuff, if you feel you've answered it already, just tell me. You don't have to repeat yourself. So the next question is, what was the best part and then what was the worst part, when you did have your daughter?

A: It's difficult to describe, the best part is just, she's just a lovely baby. Sort of... she's just a real character from the beginning. Just got on with me, so determined and she seemed to have so much sort of, in there just when she was born cause of her character, you know. Not fully formed or anything but it was, all the potential was there and she was just a lovely ? daughter really. That was the best thing.

Engaging personality of baby.

Sense of potential/possibility for the child.

Q: And the worst thing?

A: The worst thing is the worries that come with it. The worrying about, you know, if you're being a good parent or you know, or if you're gonna cause harm somehow to the child. Just the worry of being a parent I suppose, and just worrying about, you know, just worrying that you're doing a good job of being a parent. That's the hardest. And lack of sleep. I don't know if I can say both, but the tiredness, it was really difficult.

Worried if good enough parent.

Worried about somehow harming the child.

Q: The tiredness?

Lack of sleep.

A: Yeah.

Q: So how much were you sleeping when you first had her?

Appendix 10:

IPA Stage 3: Making an ordered table of the themes from the second stage, and illustrating these themes with quotes from the transcript.

IPA Stage 3:

Making an ordered table of the themes from the second stage, and illustrating these themes with quotes from the transcript. (Extract from analysis of F8)

Positives of parenting

Fed child and felt attachment

"I immediately felt, you know, attached to her. Straight away. Cause I fed her as soon as she was born." (F8)

A character, the way child reacts to the world

"Even when (daughter) was born she seemed to have, you know, some sort of a character there already, the ways she... reacts to the world." (F8)

Happy child, life affirming – jogs me out of the depression

"...she's such a happy child, sort of quite life affirming. It jogs me out of the depression that used to sort of get me down..." (F8)

Responsibility motivates coping

Someone to look after gives you motivation to cope with mental illness

"...someone you've got to look after helps...it gives you motivation to cope with it (illness) and get on with the practical things..." (F8)

The responsibility – they're helpless, relying on you for everything

"Well it goes back to the sort of responsibility thing, that...they're relying on you for everything. Especially initially they're so helpless." (F8)

You've got a purpose, doing something positive

"...makes you feel you've got a purpose in a way and you know, you're doing something positive, bringing up your daughter." (F8)

A more positive self-image from the positive contribution

"Getting a more positive self-image really, that I had a role and I had a positive, something to contribute. So it did increase my confidence..." (F8)

With a child, you're not as threatening

"...people are more approachable when you've got a child, you're not as threatening in a way. So more people talk to you." (F8)

It's a lot more reward than the problems

"...overall it's been a lot more reward than the problems it's brought." (F8)

Appendix 11:

IPA Stage 4: Consolidating master lists of each interview into a list of master themes.

IPA Stage 4:

Consolidating master lists of each interview into a list of master themes. (Extract from list of master themes)

A SENSE OF PURPOSE

The responsibility – they're helpless, relying on you for everything

"Well it goes back to the sort of responsibility thing, that...they're relying on you for everything. Especially initially they're so helpless." (F8)

You've got a purpose, doing something positive

"...makes you feel you've got a purpose in a way and you know, you're doing something positive, bringing up your daughter." (F8)

Role of providing for child

"...I think I'm a good dad. Cause I'm there for him, I make sure he's got clothes, I make sure he's got food..." (F9)

Responsibility for family

"Well I was always there for my kid and my partner. And like, I made sure they come first and me last... always made sure of that." (F9)

Caring role

"I looked after him as best I could. Fed him and everything." (F5)

Sense of identity

"It's become part of me. It's just become wholly part of my self image, that that's what I am." (F10)

Hope to guide son in spirit after I die

"I always felt I'll enter through a spirit. Enter through (grandson's) body and try to guide him on, you know? Guide him through it. All this dying thing again, you see. Very spiritual stuff, dying you know." (F5)

Provider for family

"...I wanted to feed them as much as I could..." (F4)

Appendix 12:

IPA Stage 5: Communicating the final list of master themes in the form of an account illustrated by quotes from the transcripts.

IPA Stage 5:

Communicating the final list of master themes in the form of an account illustrated by quotes from the transcripts. (Extract from results section)

A sense of purpose

Many of the fathers described the sense of purpose and meaning that fatherhood brought to their lives. This was associated with taking on the responsibility for providing for one's children: *"...I think I'm a good dad. Cause I'm there for him, I make sure he's got clothes, I make sure he's got food..."* (F9). **It appeared that the sense of responsibility felt by the fathers was associated with an awareness of their children's dependency:** *"Well it goes back to the sort of responsibility thing, that...they're relying on you for everything. Especially initially they're so helpless"* (F8).

It is apparent from the following quote the incredible degree of responsibility that the fathers can feel towards their children. This particular father said that even death would not prevent him from guiding his son:

I always felt I'll enter through a spirit. Enter through [grandson's] body and try to guide him on, you know? Guide him through it. All this dying thing again, you see. Very spiritual stuff, dying you know. (F5)